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*Volume 1*

# Transcript of Proceedings

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

REGIONAL MEDICAL PROGRAMS SERVICE

REVIEW COMMITTEE

Rockville, Maryland  
Wednesday, 17 January 1973

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HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

REGIONAL MEDICAL PROGRAMS SERVICE

- - -

Review Committee

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Conference Room GH  
Parklawn Building  
Rockville, Maryland  
Wednesday, January 17, 1973

The meeting convened at 8:40 o'clock a.m., Dr.  
Alexander Schmidt, Chairman, presiding.

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P R O C E E D I N G S

DR. SCHMIDT: I have been waiting for some juice to get through the PA system here, and we are still having a little technologic difficulty. But I think that we can get through, at least my part of the meeting, without the benefit of the PA system. Years of lecturing in large lecture halls which also have problems with PA systems have led me to develop a penetrating voice that I hope carries to the back of the room.

So I will call the meeting to order and welcome everyone here, this first meeting welcoming the members of the committee and staff and also at this meeting any public members who might be here. This meeting as you all probably know, is the first one that is being conducted in accordance with the Federal Advisory Committee Act, P.L. 92-463.

And all committee members have with your agenda materials the rules for conduct of RMPS public advisory group meetings. And there is no particular need to look at this now, but it is kind of interesting and gives some ground rules for the conduct of these meetings and the participation of the public guests who may choose to join us during the open portion of the meeting.

I would direct your attention to at least one guest that I know of. Dr. Al Florin is here representing Dr. Ingles and the steering committee of the coordinators. Later on today,

1 Dr. Phil White will join us, an old committee member, to cover  
2 one of the applications.

3 We have found it necessary because of a conflict with  
4 another meeting that is scheduled to look at change of date  
5 for the May meeting. And we need to pick days during the week  
6 of May 7 to 11. Those of you who bring your calendars may want  
7 to check that out and pick days of the week for this. Wednesday  
8 and Thursday would be the 9th and 10th. As I recall previous  
9 discussions, the committee is kind of settled on Wednesday and  
10 Thursday as being good days which would make it the 9th and  
11 10th.

12 Are there objections to those days?

13 (No response.)

14 If not, then we will settle on those.

15 The other days are September 12 and 13 in 1973,  
16 January 16 and 17 in 1974, and May 15 and 16 in 1974. We hope  
17 that is not anticipating anything too much.

18 I have a letter to the Regional Medical Programs  
19 Review Committee that was given to me a minute ago by Dr.  
20 Margulies from Vern Wilson. And I would like to read that  
21 letter to the committee. It says:

22 "Ladies and gentlemen:

23 "By the time this reaches you, I will have already  
24 left the position of Administrator of the Health Services and  
25 Mental Health Administration to return to the University of

1 Missouri. I feel I would be remiss if I did not express my  
2 sincere sense of gratitude for the considerable advice and  
3 counsel you have provided to me and to HSMHA during my  
4 incumbency.

5 "Please accept my thanks and most sincere wishes for  
6 the successful pursuit of your personal goals. I hope we will  
7 meet many times in the future in our joint efforts to improve  
8 health care for the people of our country.

9 "Best personal regards, Vernon Wilson."

10 Some people have asked me what Vern was going to do  
11 in Missouri and particularly was he returning to his academic  
12 vice presidency. And the answer to that is he is going back as  
13 a tenured professor and will be teaching and in activities  
14 having to do with community medicine and perhaps his discipline.  
15 I am sure that the opportunities for Vern will be many, and he  
16 will be able to select among many excellent opportunities to do  
17 what he wishes. But he won't be going back as the academic  
18 vice president.

19 There is a reorganization of the Medical Administration  
20 in Missouri as many of you know. And they will be choosing some  
21 vice provosts and so on. And how that will settle out no one  
22 knows.

23 But it is appropriate, then, to lead from a note from  
24 Vern Wilson to Dr. Margulies and the third agenda item, the  
25 report from Dr. Margulies and the Regional Medical Programs

1 Service. So I will turn the microphone over to Harold.

2 DR. MARGULIES: Thank you, Mac.

3 The Review Committee may feel a little more prestigious  
4 than usual for the moment. If you have read what has been  
5 happening since the election, there is virtually nobody left  
6 between you and the President of the United States in HEW.  
7 So you are very close to the seat of power.

8 We tried to arrange the meeting to be at Camp David  
9 but the roads were bad and the helicopters weren't flying.

10 I have a few announcements to make to you which have  
11 to do with specific situations within the REgional Medical  
12 Programs and would like to go through a number of other  
13 information items before we get to the reviews themselves.  
14 Some of them have to do with changes in leadership in Regional  
15 Medical Programs which are very key events as you all know  
16 from having reviewed RMPs.

17 There are three Regional Medical Programs which  
18 you knew were seeking new coordinators and which have in fact  
19 selected and officially appointed new coordinators. One of  
20 them is Albany where Frank Woolsey has resigned and has been  
21 replaced by Dr. Girard Craft who has been with that program for  
22 some time and is fully familiar with the activities and  
23 purposes of it. Frank resigned with a very positive feeling  
24 that he had been able to do a good many things that he would  
25 like to get done and with the strong feeling that it was time

1 for him to take it a little easier and have a different kind  
2 of leadership. And it looked very positive.

3 As you may recall, in Iowa, there was also a search  
4 for a new coordinator because the one who had been there had  
5 left so that he could move with his family to Florida. The  
6 new coordinator there is Charles Caldwell who again is an  
7 individual who has proved his value as a member of the staff  
8 and is a very capable individual. He was acting from the time  
9 that Dr. Weinberger left and has become coordinator since  
10 October.

11 And in Oklahoma where Dale Groom retired around  
12 September of 1972 of the past year, a new coordinator has been  
13 selected. That is Al Donnell, D-o-n-n-e-l-l. He is a lifetime  
14 Oklahoman as I recall and has been very active in the general  
15 hospital field and is keenly interested in the whole concept of  
16 regionalization, has worked with the RMP and appears to be a  
17 very attractive choice.

18 There have also been some resignations since we were  
19 last here. And I will just go through those quickly.

20 Dr. Wentz from Metro D.C. has resigned, and there is  
21 a search for a new coordinator.

22 Dr. Jay Brightman in New York Metro RMP has resigned,  
23 and Dr. Aronson is acting. And there is a search for a new  
24 coordinator.

25 Dr. John Lowe in South Dakota left in October. And

1 Donald Brekkee is acting there. And they are searching for a  
2 new coordinator.

3 And we just received that Dr. Henry Clark is  
4 resigning as of May 1 from the Connecticut RMP. I talked  
5 yesterday with Mr. Rogers who for a good many years was  
6 chairman of the Regional Advisory Group in Connecticut. He  
7 described the way in which they are setting up a search committee  
8 We were especially interested there because there has been a  
9 kind of uneasiness in the Connecticut RMP between themselves  
10 and the State Medical Society or at least some members of the  
11 Executive Committee of the State Society.

12 They appear to have good accord in the method of  
13 search for a new coordinator. And the president of the  
14 State Medical Society is on the search committee.

15 There are some regions which have not yet made a  
16 final selection of new coordinators where there is an acting  
17 arrangement. Indiana is one where Dr. Beering is acting.  
18 He is Associate Dean, as I recall.

19 In Intermountain, Richard Haglund who for years has  
20 been on the staff has been acting coordinator for quite some  
21 time since Dr. Sadavik resigned. And they are still trying  
22 to find a new coordinator. I will get back to that in a moment  
23 because there are some issues there.

24 In Western Pennsylvania, Dr. Reed had agreed to  
25 stay on for one year. That year will be ending in the near

1 future. There is a search committee for a replacement for him.  
2 In the case of western Pennsylvania, you will recall that the  
3 coordinator had resigned to seek another academic position  
4 so that that one has been open for a period of time.

5 One other change which is of some interest is in  
6 Texas where a new grantee has been arranged for. This was done  
7 with mutual understanding on the part of the university, the  
8 State Medical Society, the Regional Advisory Group. It appeared  
9 that the involvement of the medical school could remain very  
10 full with a grantee which was a nonprofit organizational  
11 structure and was actually done under the aegis of the  
12 university and with their strong support. That began on  
13 January 1 and appears to be a satisfactory activity. And there  
14 will probably be something similar which will evolve from the  
15 Metro New York RMP although that is not yet official.

16 You may also recall that we did distribute during the  
17 past several months a very explicit policy statement regarding  
18 the relationships between the grantee, the Regional Advisory  
19 Group, and coordinator and his staff. This is something which  
20 had long been asked for. There had been uncertainty in many  
21 instances about what that relationship should be.

22 We have had discussions here. We had extensive  
23 discussions with the Council. It finally did receive endorsement  
24 and was distributed. With one exception, it has been greeted  
25 either with enthusiasm or with accord which requires some

1 adjustment in the organization of Regional Medical Programs.  
2 Most people felt that it was overdue, that the statement was  
3 clear cut and did not represent an unsatisfactory way of  
4 conducting the business of a Regional Medical Program.

5 The exception most notoriously is in the Intermountain  
6 Regional Medical Program where the administration of the  
7 university feels considerable discomfort with the idea of a  
8 Regional Advisory Group making decisions which they feel should  
9 be made exclusively by the grantee. That issue remains unresolved  
10 And as I hinted a moment ago, it is probably one of the reasons  
11 why there has been some delay in the final selection of a new  
12 coordinator. I really don't know what decision they are going  
13 to make in Intermountain about adjusting to that policy or  
14 selecting a new grantee, whatever may be the situation.

15 But aside from that and some restlessness at least  
16 in Tennessee mid-South, we have had no real difficulties with  
17 that statement. And for the most part, the response has been  
18 a very positive one.

19 I think that it would be fair to say in Dr. Florin's  
20 name that New Jersey is making some changes in its organiza-  
21 tional structure to accommodate it, but it doesn't appear to be  
22 too much of a problem. In that case, as was rarely the  
23 situation, the Regional Advisory Group and the grantee were  
24 essentially the same. And this requires some new organizational  
25 structure to continue doing business, but to be consistent with

1 HEW policy.

2 Now, let me get on the subject of the budget for a  
3 moment because there may be some casual interest in the subject.  
4 We continue to be operating under a continuing resolution  
5 which for those who have not fully enjoyed that kind of an  
6 arrangement, I will provide an explanation.

7 When there has not been an Appropriation Act passed  
8 Congress may pass a continuing resolution which allows the  
9 program affected -- in this case, those in HEW for which  
10 appropriations have not been made available -- to continue to  
11 operate on the basis of one of two alternatives -- either the  
12 level of budgetary allowance of the preceding fiscal year or  
13 the budget which was proposed by the President to Congress for  
14 the current year, whichever is lower.

15 Now, there was no gross difference between 1972 and  
16 the proposed budget for 1973. So we have been operating at  
17 essentially the same level of activity during that period of  
18 two years. There were two Appropriation Acts passed by  
19 Congress, and they were both vetoed. Congress is now in  
20 session and, of course, can pass another Appropriation Act,  
21 can continue under the continuing resolution, and can do the  
22 latter for an indefinite period of time. And we don't know  
23 what they are going to do.

24 During the period of time when we are on a continuing  
25 resolution, we continue to act according to those kinds of

1 rules. However, when it is as late in the year as it is at  
2 the present time, it requires a certain amount of fiscal  
3 prudence on our part and on the part of OMB. And so the one  
4 accommodation we have made until the budget for this fiscal  
5 year which is now more than half over has been determined is  
6 to limit the duration of grant support for programs which  
7 began January 1 -- not the amount, not the level, but the  
8 duration of support.

9 We could not for programs which had their beginning  
10 date of January 1 provide funds for the full 12 months. So  
11 what we were allowed to do was release grant funds at the  
12 level anticipated for the full year, but only for the first  
13 6 months until there is an appropriation and a final decision  
14 on fiscal 1973 and some action on fiscal 1974.

15 Now, I suspect that what will happen, and it is  
16 really more than a suspicion -- it is based upon what informa-  
17 tion I have received -- is that when the President does  
18 present his budget message which is scheduled for January 29,  
19 it will include some recommendations for fiscal 1973. These  
20 will not necessarily be the same as those that were proposed  
21 by the Administration at the beginning of the fiscal year, but  
22 will be adjusted to the fact that we are well into this fiscal  
23 year and will reflect whatever kinds of recommendations are  
24 made for the subsequent fiscal year. I think it is fairly  
25 obvious that the pattern from one fiscal year to the next has

1 to remain reasonably consistent.

2 Congress will, of course, receive that information  
3 and act according to the way in which Congress feels that it  
4 should. It has the choice of passing an Appropriation Act  
5 at any time, of course. It could do so today if it wished to  
6 do so or wait for the budget message or act on the same day.  
7 And there is no way of predicting what will actually be done.

8 So we are really no clearer in our understanding  
9 of what our level of support will be now than we have been in  
10 the past. That means, although I am getting into the issue  
11 of review now which is a closed part of the meeting -- I may as  
12 well comment on it -- that we will continue, I hope, to do  
13 what we have in past years. And that is carry out a review  
14 process in which we look at what has been proposed by a  
15 Regional Medical Program, examine the application and draw a  
16 judgment based upon the merits of that application and not try  
17 to figure out what the budget is going to be when we don't know  
18 what it is going to be. That is an issue which is separate  
19 from the review of programs based upon their individual  
20 merit. And this Review Committee has been able to do that  
21 quite effectively in the past, and I am sure they can in the  
22 future.

23 Are there any questions about that illuminating  
24 statement?

25 (No response.)

1 I would like to mention to you that the steering  
2 committee of the REgional Medical Programs will be meeting  
3 in January, and there will also be a general meeting of all of  
4 the coordinators. And I would like to take a moment if I may  
5 to refer to the activities of the coordinator steering committee  
6 so that you can appreciate what kind of an assistance they have  
7 been.

8 During the past several years, the coordinators  
9 have felt that they can establish a more effective working  
10 relationship with the Regional Medical Program Service if  
11 they have selected representatives who meet together as a  
12 steering committee to bring to us information which they feel  
13 is not readily available to us and which represents a consensus  
14 of coordinators' concerns and to receive from us information  
15 which can be distributed rapidly to the coordinators.

16 Now, the coordinator groups within themselves are  
17 organized on a sectional basis. And so they meet Northeast,  
18 Southeast, West, Mid-continent, and so forth. They meet at  
19 regular intervals around the meetings of the steering committees  
20 and around their own kind of business. When the steering  
21 committee meets in January, it will take advantage of the fact  
22 that there is to be a conference on quality assurance. It will  
23 also be an opportunity for all of the coordinators to meet to  
24 elect new officers and to consider any business they want to  
25 consider.

1           That particular meeting is not one which is called  
2 by the Regional Medical Programs Service. That is, the meeting  
3 of the coordinators is not. They call that to conduct their  
4 own business, to examine their own affairs, and do what they  
5 think they need to do. If they want to invite us to be present,  
6 we are present. If they have some other business to conduct,  
7 then we are not present. And it seems to be a very effective  
8 kind of arrangement.

9           The meeting which then follows for the next two days  
10 on the examination of the professional issues involved and  
11 quality assessment and assurance is an invitational meeting  
12 and is an official part of Regional Medical Programs Service  
13 activities. That meeting which is to be held in St. Louis  
14 looks awfully good. We have been working on it modestly begin-  
15 ning a little over a year ago and with an increased tempo  
16 during the past several months. We made several decisions  
17 about it early on which we have stuck with and which have  
18 appeared to be a pretty good idea.

19           The basic one is that the meeting is to provide an  
20 opportunity for Regional Medical Program coordinators and for  
21 others who are interested to examine in a professional way the  
22 major issues which are involved with quality assessment and  
23 assurance. There is no effort involved in this activity.  
24 The quality assurance conference is not designed to examine  
25 new legislation. We are not there to consider PSRO or some

1 special kinds of activities. And it is very scrupulous in  
2 its approach. It is entirely designed around our understanding  
3 that there has been a whale of a lot of work going on for the  
4 last several years to look at all of the aspects of quality  
5 assessment and assurance.

6           There are some very competent people who we would  
7 like to hear from. And that is exactly the way it is designed.  
8 But in order to make sure that what appears to be unusually  
9 good input will be rapidly available, we have done two things.

10           One of them is to limit attendance and make the  
11 meeting pretty much theater kind of performance with the rapid  
12 presentation of cogent papers grouped together under general  
13 subjects, very, very limited time for discussion, with a clear-  
14 cut understanding that there will be rapid distribution of  
15 printed copies of the papers which are presented.

16           Now, there will be approximately 28 people who will  
17 have something to say in a formal way. We have plans to  
18 bind and distribute the papers within no longer than about 30  
19 days after the meeting. We have already received something  
20 like 20 completed papers which is remarkable in itself. And  
21 I think that we will probably get, if not all, virtually all,  
22 of the papers completed, ready for binding and for distribution  
23 by the time the meeting occurs. That means that we can  
24 achieve our major purposes which is to have a discussion of a  
25 presentation and have the widest possible distribution.

1           Because of the quality of the conference, we are  
2 going to print an extraordinarily large number of volumes of  
3 the quality conference material and give them very wide  
4 distribution. This allows us to feel more comfortable with the  
5 limited attendance. If we had opened the attendance even by  
6 word of mouth, the number of people we would have to accommodate  
7 is staggering. We learned that within a few days. And since  
8 there was no way to compromise on that, we decided to make it  
9 a Regional Medical Program activity and restrict it accordingly.

10           We do know that some members of this committee are  
11 planning to attend. At the present time, we understand that  
12 this will include Ancrum, Anderson, Ellis, Kerr, James, and  
13 Thurman.

14           There is an agenda which is in your book which is  
15 Attachment B.

16           Now, one final thing that I would like to mention  
17 to you -- well, there are two or three things which we should  
18 mention in passing -- just to make sure that you do get all the  
19 news about what has been happening within our structure. I  
20 think you all know that Dr. DuVal has resigned as Assistant  
21 Secretary for Health. You do know that Dr. Wilson has left  
22 as the Administrator of HSMHA, that Dr. Marston has left as  
23 the Director of the National Institutes of Health -- has not  
24 left, but has resigned as the Director of the National  
25 Institutes of Health. At the present time, the Acting

1 Administrator -- and it is clearly on an interim basis --  
2 for Health Services and Mental Health Administration is Dr.  
3 David Sencer who is the head of the Center for Disease  
4 Control in Atlanta. That is a program director within HSMHA.  
5 This is an arrangement until a new Administrator has been  
6 selected.

7 Dr. Stone who is acting as Deputy has also taken over  
8 the role of Acting in the position which Jerry Riso was serving  
9 as the Deputy Administrator for the development group. And  
10 that also is obviously an interim arrangement until the new  
11 positions have been filled.

12 I think that there is just one other thing which I  
13 would like to comment on and then perhaps, Herb, you might want  
14 to pick up on any other items that we need to present for  
15 information purposes.

16 As a reminder, the REgional Medical Program legisla-  
17 tion has to be extended in whatever form it will be extended  
18 within the current fiscal year. It is one of several programs,  
19 one of an extraordinarily large number of programs, which will  
20 terminate June 30 without new legislation. There have been  
21 a number of activities around the country in preparation for  
22 new legislation. What the form of that legislation will be,  
23 whether it will modify the directions of RMP, whether it will  
24 address other programs in conjunction with RMP, is a matter of  
25 speculation. It appears likely, however, that there will be a

1 good many suggestions, and I know some testimony to Congress,  
2 proposing more specific kind of language to describe the mission  
3 of Regional Medical Programs and probably increased attention,  
4 whether it is in the form of Congressional language or in  
5 legislation, to the relationship between Regional Medical  
6 Programs and other Federal health activities, most specifically  
7 Comprehensive Health Planning. The relationship between the  
8 two, the definition of the two, has continued to disturb people  
9 since the legislation was first passed. And despite some  
10 strenuous efforts to reach some clarification, it continues to  
11 be confusing.

12           So that we may see anything from language of clarifi-  
13 cation to some modification to some restriction or some new  
14 direction, I am not sure what. But I think you will all be  
15 interested in following the progress. And in this particular  
16 case, I think that if you want to take the time, and it is  
17 easier to do it as it goes on, some of the congressional  
18 discussion may be of more value in some ways than the final  
19 form of the legislation because it is extremely difficult to  
20 write legislation which is as explicit as congressional  
21 understanding would have it be. This begins to bind the  
22 legislation so that it is not maneuverable. And I believe you  
23 will be interested in following that kind of an activity.

24           I do not know what the schedule is for congressional  
25 hearings either in the Senate or the House for new legislation.

1 Are there any questions on these issues?

2 (No response.)

3 Let me just get on two other subjects which are more  
4 specific and have to do with professional activities with which  
5 we are concerned. Both of these, we have discussed in the  
6 past and they have to do with the development of stronger  
7 working relationships and a more effective programmatic link  
8 for both cancer and heart disease:

9 As you know, during the past year, there was an  
10 increased amount of emphasis put on cancer in the National  
11 Cancer Institute, heart disease in the National Heart and  
12 Lung Institute, with some reorganization, with the proposal for  
13 greater support, greater financial support, for both of these  
14 areas of activity. We have had, therefore, during the past  
15 year a number of activities which have looked toward an  
16 identification of the ways in which those Institutes and the  
17 Regional Medical Programs can work effectively together.

18 As I have said to you in the past, what we would  
19 like to see is a definition which is evolving of the roles  
20 of the Institutes and of the Regional Medical Programs which  
21 I think from our point of view are fairly evident. It is  
22 clear that the NIH is a source of research, biological research,  
23 as RMP is not. It is also clear that the National Institutes  
24 are in a good position to identify major disease activities,  
25 major kinds of approaches to disease control, which they are

1 interested in seeing developed or which they think are ready  
2 for development and for which they can turn to the Regional  
3 Medical Programs for rapid expansion and for extension into the  
4 health care delivery system. This, in fact, is totally consistent  
5 with the original concept of Regional Medical Programs which  
6 was to do exactly that kind of thing.

7           Now that the RMPs are nationwide and are dealing in  
8 a kind of a network of activities within their regions and  
9 across the country, the possibilities of doing this have been  
10 increased. One of the better examples of what has already been  
11 selected as a major target, I am sure you know, is the  
12 secretariially sponsored program to establish a national  
13 hypertension control activity. During the last two days, on  
14 Monday and Tuesday of this week, there was another national  
15 meeting to address this problem.

16           It is the general understanding of the people who  
17 have been involved that hypertension is a disease of great  
18 prominence, that it is probably afflicting some 23 million  
19 people in the United States. Of that total number, a relatively  
20 small number, perhaps not more than one in eight, is diagnosed  
21 and under effective treatment.

22           It is also believed by those who have been working  
23 most fully in the field that the methods of management by  
24 drug therapy are at a point of great enough effectiveness so  
25 that a nationally designed -- nationally in the sense that it

1 covers the nation but is regional and local in effect --  
2 program is perfectly possible developed around the concept of  
3 screening, of referral, of drug therapy, and of maintenance,  
4 understanding that this will require networks which will utilize  
5 physicians not exclusively, but rather for general guidance,  
6 and a good many other people for screening, maintenance, and  
7 for control.

8           The energy behind this is very great. In the  
9 meeting in the last two days, there were assembled people from  
10 many, many sources -- from medical societies, from voluntary  
11 health agencies, from industry, from labor, the pharmaceutical  
12 industry. The persons who were presented represented the  
13 views of the Secretary himself, speaking for himself, the  
14 current Secretary, Mr. Richardson -- and he gave us assurance  
15 that Mr. Weinberger had already accepted the importance of this  
16 as something he would continue -- the Commissioner of the FDA,  
17 NIH, HSMHA, all were fully committed to this activity. And we  
18 anticipate that it will be a major part of RMP activities in  
19 the future as well.

20           In fact, it was sort of heartwarming to me, excepting  
21 for one minor problem that they never mentioned, that a good  
22 bit of what was represented as examples of how to control  
23 hypertension was RMP supported. I was sitting in the front  
24 row listening to one example after another of the way it had  
25 been done. And I never heard the words "Regional Medical

1 Program" come out of it. Well, we are sort of used to that  
2 anonymity, but it happened to be a season in which I could  
3 have selected a little different way of describing our work.

4 Jerry Stamler presented a magnificent summary of  
5 current knowledge on the subject of hypertension, diagnosis  
6 and treatment. And I would say that 8 out of 10 of the  
7 examples that he chose of ways in which the disease could be  
8 managed were based on something which had been sponsored by  
9 Regional Medical Programs.

10 So it will not be a new undertaking, but it will  
11 certainly represent a channeling of energy which I think would  
12 be very exciting. It is one of those kinds of things which  
13 can be achieved in a relatively short period of time which I  
14 am sure you will hear a great deal more about.

15 Now, in the field of cancer, it will require further  
16 definition than we have had at the present time. But we are  
17 looking to those Institutes -- NHLI and the National Cancer  
18 Institute -- to give us a definition of those directions in  
19 which they would wish to go. We will need to work out more  
20 clearly the arrangements for staffing activities, for funding  
21 activities, and so on. But I think that we are now in a  
22 position to serve the public interest and to take advantage of  
23 a momentum which has been regenerated rather than newly  
24 generated.

25 Do you have anything?

1 DR. PAHL: Just one thing, perhaps. We have been  
2 talking somewhat seriously, and I would like to just share a  
3 personal observation with you and then make one point of  
4 information.

5 In recent days, it has become very important to me  
6 to go back to President Truman's observation as to when the  
7 presidency fell into his hands. And I just want to share with  
8 you that Dr. Margulies didn't take full vacation time last  
9 summer and so some time back decided that over the holidays,  
10 he would take a few days leave. And it was my good fortune  
11 perhaps to have on the very first day that he was not in charge  
12 of our program and therefore I was completely in charge the  
13 Washington Post indicate just how important it is to have our  
14 Director here full time. And I believe that from now on, I  
15 would prefer if you didn't take leave, at least, and notify  
16 everybody.

17 The only point of information I would want to share  
18 with you is that in a continuing effort to improve the  
19 management of our program, we have indicated to you that over  
20 many, many months a policy manual has been under development  
21 so there will be a single reference point for both our own  
22 staff and all of the staffs of the regions when it comes to  
23 what our policies are relative to the governing of the program.  
24 And that policy manual through the cooperative efforts of  
25 many, many of our staff has now been developed. And we have

1 even managed to clear it through all the official channels  
2 so that we are in a position probably immediately after the  
3 St. Louis meeting to mail it to the regions where we will be  
4 asking the staffs to comment on the content and then following  
5 a consideration of those comments, we will revise it and send  
6 it out in completed form. So I believe that we are trying to  
7 pursue what we believe to be improved management practices.  
8 And this, I think, is a very major step forward and is, I  
9 believe, so recognized by the regions.

10 And I want to take this somewhat public opportunity  
11 to again thank our own staff for really the many months of  
12 effort and intensive effort in recent weeks to get it to this  
13 particular point.

14 DR. SCHMIDT: All right, thank you very much.

15 Dr. Ellis.

16 DR. ELLIS: May I ask a question of Dr. Margulies,  
17 please, Mr. Chairman?

18 Dr. Margulies, we are hearing quite a bit about  
19 specialized revenue sharing for health. And I was just wonder-  
20 ing that in the event that a decision is made to make bloc  
21 grants to the States for health, do you see that this in any  
22 way would affect the way the Regional Medical Programs would  
23 operate or the legislation? I ask this because it is necessary  
24 to know in talking to so many people exactly how to comment  
25 on this to the best advantage.

1 DR. MARGULIES: As I said the last time that question  
2 came up, that is a very good question. However, I will be a  
3 little more helpful this time. That is all I said last  
4 time.

5 I think there is no question about the interest in  
6 the Administration in promoting the concept of State revenue  
7 sharing. That has been the President's position. It was  
8 initiated during the last session of Congress.

9 There also has been an interest in what is probably  
10 incorrectly called revenue sharing in health. It really is a  
11 matter of grant consolidation with State management of the way  
12 in which the funds are being used, with greater latitude on  
13 the part of the State than they have under present categorical  
14 circumstances.

15 I think there is no question also that that kind of  
16 arrangement is one which could be proposed only by the  
17 Administration, but which would either be accepted or rejected  
18 by Congress. And I think there is some likelihood that an  
19 increased effort in that direction will be mounted by the  
20 Administration. But I think it would be rather useless  
21 speculation to try to answer the question beyond saying that  
22 there will really be two issues.

23 One of them is whether that kind of an approach to  
24 the support of health activities is acceptable to Congress.  
25 And that would be debated, I am sure, very vigorously by

1 Congress.

2 And, secondly, whether if that did pass, it would  
3 include Regional Medical Programs.

4 Now, if one were to include RMP in a kind of bloc  
5 grant arrangement with the determination of support to be made  
6 at the State level, it would obviously mean a different  
7 Regional Medical Program. About that, there is no question.  
8 But at the present time, I have seen no legislation introduced  
9 which describes that kind of an activity.

10 I am not in any doubt that it probably will be. But  
11 until something of that kind does get introduced, until there  
12 is debate, until there is decision about it, there isn't  
13 any reason for us to consider it as anything other than an  
14 idea which is going to have to be somehow deliberated between  
15 the Administration and Congress.

16 The nature of Regional Medical Programs, as you  
17 understand better than anyone else in the Review Committee,  
18 requires a different kind of an approach as we have currently  
19 understood it to be. And so if there should be that kind of  
20 a basic change, it would really change all the rules of play.  
21 And then we would have to go at it in a totally different  
22 manner. But at present, there is no proposal of that kind  
23 which has been presented to Congress and which is under  
24 general consideration.

DR. ELLIS: Thank you.

1 DR. SCHMIDT: I won't ask if that answers your  
2 question. I will ask if that satisfies you.

3 DR. ELLIS: Yes, it helps greatly.

4 DR. SCHMIDT: I don't think there is an answer to  
5 the question. Basically, of course, the problem is there  
6 isn't enough money to go around to do things everybody recognizes  
7 as good. So in this instance, somebody has to decide where  
8 the money is going to be. And my own personal interpretation  
9 of things is that Congress is unable to make these decisions  
10 right now. It isn't equipped to do it.

11 There is some question about whether or not they have  
12 the authority to do it. If you looked at the Washington Post  
13 this morning, I think it was Congress is talking about some  
14 kind of their own super budget agency, Congress' own Office  
15 of Budget and Management, that would vie with the executive  
16 OMB. This sort of a thing could share in the decision-making  
17 of where limited numbers of dollars are going to go. But I  
18 don't see that in the next four years myself.

19 And what I do see is an increasing number of dollars  
20 placed at the State level with the decision-making being put  
21 at the State level. And in Illinois, since you are familiar  
22 with Illinois, I now see the amusing business going on of  
23 everybody trying to divorce themselves from the health centers,  
24 for example. The Mile Square, which is very well known, is  
25 having its funding pulled back by the Federal Government. And

1 Presbyterian St. Luke's Hospital is trying to pretend like they  
2 have never heard of Mile Square. Martin Luther King is being  
3 peddled to Cook County Hospital of the University of Illinois  
4 because their funding which is now about \$2.5 million a year --  
5 I think they see a couple hundred patients a year, something  
6 like that, for that money -- everybody is pretending like it  
7 doesn't exist.

8           And what is going to happen is that I think that  
9 President Nixon will say to the State of Illinois, "I have  
10 given you this money, you now have these programs, and you  
11 decide what the State will support." And the State will be  
12 deciding what to phase out, what to keep, what to put together,  
13 and I suppose might even be deciding what of RMP should be  
14 supported in another few years.

15           Whether this will last when Congress really does find  
16 out that the money that is accrued by its taxation authority  
17 is being spent by States in the next Administration, I would  
18 rather doubt. These things are kind of fun to think about and  
19 to predict the future with. But I don't think people really  
20 know.

21           DR. MARGULIES: I think you should realize that the  
22 idea of Congress having a sort of super OMB of its own kind  
23 was generated in the period of depression following the Super  
24 Bowl and they felt they needed to reconstruct the conflict at  
25 a higher level. I don't know whether they worked out the

1 television rights, but it should be an interesting show if  
2 they bring it around.

3 DR. SCHMIDT: I don't think the Super Bowl was  
4 all that interesting myself.

5 Well, we do have a number of progress reports, or  
6 a few progress reports on various activities that have been  
7 supported through supplemental funding. And the first of these  
8 relates to health services and educational activities. And  
9 Veronica Conley will give us a report.

10 Veronica.

11 DR. CONLEY: Thank you.

12 Dr. Schmidt, Dr. Margulies, as was reported to the  
13 committee at its last meeting, 57 health service education  
14 activities which are located within 25 RMPs were funds in  
15 June 1972. Since that time all conditions for funding which  
16 were imposed during the review process have been satisfied.

17 At this point in time, all but a few projects have  
18 full-time directors and are moving ahead very satisfactorily.  
19 They are in all stages of development, varying from the  
20 fully operational San Fernando Valley Consortium, LAHEC in  
21 Erie, Pennsylvania, and TANEC in Tuskegee, to the Batesville,  
22 Arkansas, HSEA whose director just reported last week.

23 The directors appear to be predominantly from the  
24 field of education, some of whom have had little experience  
25 with the health services delivery system. Many of the directors

1 have expressed the need for more orientation to the RMPS  
2 concepts for HSEAs and to RMPS policies.

3 Communications between the projects and the RMP  
4 staff is complicated by the great geographical distance between  
5 the RMP office and the project sites in many regions. They can  
6 be 150, 200 miles from the office.

7 Over the last few months, the need for more  
8 orientation became so acute that two of the Directors of HCs  
9 planned a national meeting of HC directors. This was cleared  
10 with Dr. Margulies. This meeting was held Monday and Tuesday  
11 of this week in St. Louis. One hundred fourteen persons were  
12 in attendance representing 36 RMPs. On the basis of attendance  
13 at that meeting and as a result of many contacts which we had  
14 in the past with the developing HCs, we have made some observa-  
15 tions which we would like to pass on to you.

16 The directors have reported a general lack of manpower  
17 planning data in the communities where they are establishing  
18 HCs, even in some cases in the presence of a CHP agency.  
19 Invariably, under the circumstances, the director sees as his  
20 first task to conduct a manpower survey. All directors need  
21 encouragement to look at health services needs as a data base  
22 in addition to the more traditional types of surveys.

23 In the area of consortium formation, two problems  
24 have arisen -- one the issue of whether to incorporate or not,  
25 and the issue of consumer involvement.

1           On the positive side, through these consortia, the  
2 RMPs have on a broader scale than ever before been able to  
3 involve educational institutions -- the technical schools, the  
4 community colleges, and the senior colleges -- none of whom are  
5 necessarily in medical centers, but all of whom are participating  
6 in the education of our health workers.

7           In six RMPs, there are AHECs which overlap with the  
8 HC projects. And we have two very fine examples of coordina-  
9 tion -- one between Northlands RMP and the University of  
10 Minnesota, and the New Mexico RMP and the University of New  
11 Mexico AHEC. The area of overlap in Minnesota is in St. Cloud  
12 where there is an HC which has developed and is the farthest  
13 in development of the Northlands projects. This is also the  
14 outreach community under the AHEC contract.

15           Through coordinated efforts, the RMP supported St.  
16 Cloud consortium will serve as the community arm of the AHEC.  
17 All relationships between the university AHEC and St. Cloud  
18 will be conducted through the consortium and not through  
19 individual agencies, institutions or hospitals.

20           In New Mexico, the AHEC contract is directed  
21 exclusively to the Navajo nation. The non-Indian population  
22 in the geographical area covered by the AHEC approached the  
23 New Mexico RMP because they wished to have the same services  
24 as the Indian population. And the New Mexico RMP is developing  
25 a section to take care of the non-Indian population in the area.

1 Areas of activity which may illustrate the potentially  
2 broad scope of activities of HCs include, for example, the  
3 Rhode Island State Medical Association which has requested that  
4 RISEC which is our HC in Rhode Island under Tri-State RMP  
5 requested that RISEC participate in PSRO planning particularly  
6 to provide advice on continuing education.

7 In Arkansas the School of Nursing has asked the HC  
8 to establish some affiliations with rural hospitals so that  
9 its persons trained at the university will have rural  
10 hospital experience and, therefore, would be encouraged to  
11 serve in rural hospitals.

12 There is also a growing surplus of nurses in Little  
13 Rock which has brought this about.

14 And another HC has been asked to represent the  
15 health community to work with architects in the planning of  
16 a hospital.

17 And, of course, several have been approached by  
18 State medical societies and local medical societies as they  
19 move towards mandatory continuing education for relicensure or  
20 for continued membership in the State association.

21 And, finally, in the meeting in the last two days,  
22 although they originally called the meeting to talk about  
23 program development, the issue which became an overriding one  
24 was what the directors call their survivability. They quite  
25 realize it will take many months and perhaps a year or more

1 before they can become self-supporting. And they are, of course,  
2 very concerned about RMP support and the possibility of its  
3 discontinuing. They explored many possibilities at length for  
4 obtaining funds, one of which was revenue sharing. And they  
5 were encouraged to immediately begin to set up relationships  
6 which would be important in any revenue-sharing activity.

7 And before they left yesterday, they appointed one of  
8 the directors to publish a regular newsletter so that they  
9 would be informed on the activities going on throughout the  
10 country in HCs and also about what is going on in RMPS.

11 And their last action was to appoint a steering  
12 committee. And its first charge was to explore ways and means  
13 how the directors both individually and collectively can  
14 assist the RMPs in the months ahead and in particular in regard  
15 to the upcoming legislation. And the chairman of that  
16 steering committee will be in touch with the chairman of the  
17 steering committee of the coordinators.

18 Thank you.

19 DR. SCHMIDT: I thank you.

20 Are there questions?

21 Bill.

22 MR. HILTON: Just a couple of small points. The  
23 PSRO is what?

24 DR. CONLEY: Professional Standards Review  
25 Organization.

1 DR. SCHMIDT: That is a nomenclature for peer review  
2 group.

3 MR. HILTON: Another thing, in your comment for the  
4 developing needs of the AHEC director, you mentioned the lack  
5 of manpower planning data and a couple of other comments you  
6 made which suggested that the system that is being developed  
7 among these project directors may be forced to replicate some  
8 of the things some RMPs -- I have visited and talked with  
9 people -- think they should be doing. Are the coordinators  
10 of RMPs familiar with these needs and is it your feeling they  
11 are responding to those things they can best do or CHPs, for  
12 that matter.

13 DR. CONLEY: Well, there is a continuing need for us to  
14 work with our regions in reorienting their thinking about how  
15 one arrives at what kinds of manpower we need and how that  
16 manpower should be trained. It is usually to conduct surveys  
17 and send questionnaires to find out how many vacancies there  
18 are, how many people are being trained. But it is our feeling  
19 that one must first look at the health services needs. And this  
20 is a new concept and one that is not easy for people to under-  
21 stand.

22 MISS KERR: I would like to ask a question if there  
23 is any distinction between "needs" and "demands." As you do  
24 surveys, we find so many indicate needs, but the employment  
25 opportunities are not there.

1 DR. CONLEY: That did come out at the last meeting  
2 and was stressed as a responsibility of the developing HCs to  
3 be sure that people trained would have positions to go to.

4 DR. ELLIS: Doctor, do any of these programs extend  
5 to education of people in the communities?

6 DR. CONLEY: They are moving into this.

7 DR. ELLIS: And how do they relate to the professional  
8 health educators as we understood it in years gone by?

9 DR. CONLEY: In the consortium representation, you  
10 would have representatives of the various health provider  
11 groups. And there are consumer representatives on the consortium  
12 as well. And as they move into the operational phase, they  
13 will move into consumer education, although each of these will  
14 probably develop quite differently from the other.

15 DR. ELLIS: Because one of the really great needs in  
16 health education is broad, across the entire population of  
17 consumers from childhood on through adult life. And I was  
18 just wondering if this wouldn't be a very important thing to  
19 build into some of those training programs. It really could  
20 be done without altering the pattern too much.

21 I think it would make a tremendous difference in the  
22 overall contribution of the program to the needs of people.

23 DR. CONLEY: This is one of the elements in our  
24 concept, Dr. Ellis, which we are trying to promote.

DR. SCHMIDT: Thank you very much, Veronica. That

1 was a very good report.

2 Emergency Medical Services. Dr. Rose will give us  
3 a briefing.

4 I believe he has a handout.

5 DR. ROSE: A rather large amount, about half of what  
6 I am passing out there, most of you have seen previously.  
7 It is a reminder and updating as to where the supplemental  
8 RMP awards of last spring went and in a general sense for what  
9 purposes they were to be spent.

10 As you will also see, there are some lists of  
11 applications, both those that went through November Council and  
12 those which are coming up now, which are offered more as an  
13 indication of how much interest has been stimulated in the  
14 RMPs to work in problems of emergency care. And I am not  
15 suggesting that is a complete list. We are still a little way  
16 from a real definition as to when a coronary care training  
17 program is heart disease and when it is EMS.

18 There is also a list of the regions that we have  
19 visited over the last few months and those that we hope to  
20 contact within the next few months. Again, a list of visits is  
21 not set in any fashion. It is largely a matter of where we  
22 feel the priorities for visits may appear and where the regions  
23 feel a need for these trips.

24 In the visits, we have been talking with a variety of  
25 people in the RMPs -- those specifically interested in one

1 particular area of emergency care, members of the RAG,  
2 executive committees, coordinators, evaluators, various kinds  
3 of people within each of the RMPs.

4 A few words about the status of Emergency Medical  
5 Services within some of the other programs around the building:  
6 CHP, the Comprehensive Health Planning Program, has expanded  
7 its interest somewhat over the last few months. They have  
8 done a series of planning sessions around the country for  
9 members of B agency staff. They have had three such meetings.  
10 The fourth one is coming up next month in New Jersey. They are  
11 designed to acquaint members of the CHP staff with the concept  
12 of planning for emergency care and the value of this care.

13 I have attended two of these meetings. I hope to  
14 attend the one in New Jersey. And I found them very interesting,  
15 although I am not sure that the audience has seen in these kinds  
16 of sessions what they would like to see.

17 As is usually the case, there is a lot of concern  
18 about how much money are we going to get and how are we going  
19 to get it and that kind of a simple question.

20 The Comprehensive Health Planning Service has  
21 also printed -- it is in the final stages now, should be out  
22 next week -- a general statement of their approach to  
23 emergency care which will be distributed to the CHP A and B  
24 agencies. And we will send it out to the RMP as well. It is  
25 an overall policy statement, not much different than the sort we

1 put out last spring.

2 What used to be called the Special Project Office  
3 for Emergency Medical Services -- I mentioned this to you last  
4 time -- this is the office which set up and monitors the  
5 contracts for model emergency medical services in five places  
6 around the country -- is likely to become, probably already  
7 has become as of this week, the Emergency Medical Systems  
8 Service. And it will include personnel from the Division of  
9 Emergency Health Services as part of their organization. A  
10 large part of their activities will continue to be the  
11 monitoring of the five model programs plus a sixth which was  
12 activated in December in Maryland and a likelihood of the seventh  
13 one which is in an innocuous phase now, being carried forth  
14 within the next few weeks or months.

15 As far as Emergency Medical Services legislation is  
16 concerned, which at the moment it appears will not affect RMP,  
17 hearings are scheduled or planned to be held on legislation  
18 very much like the Rogers bill of last year. The hearings are  
19 tentatively set for next month. It is likely that this year  
20 there will be the same bill introduced in both houses.

21 You may remember last year there was a Senate bill  
22 and a House bill. And they never came to conference. That  
23 bill relates to rather categorical EMS activities -- ambulances  
24 with people to ride on ambulances, very straightforward  
25 almost highway safety oriented type approach.

1           One final statement, if I may, about some of the  
2 concerns we have been having in talking with the regions. I  
3 think the overall concern that I mentioned last time still  
4 exists. A number of the regions are still treating emergency  
5 medical services as a separate sort of health activity apart  
6 from the rest of the thing that the RMP is interested in or perha  
7 should be interested in. And a large part of our conversations  
8 have been trying to encourage the idea of emergency care as  
9 just a requirement of the total health system rather than as a  
10 separate project.

11           In some places there has been concern about the  
12 responsibilities for contractors who have received money from  
13 these supplemental earmarked funds versus the responsibility,  
14 the management responsibility, of the RMP itself. And this  
15 has generated a fair amount of concern on our part and I think  
16 is a fairly significant problem in some of the RMPs which we  
17 hope to be talking with over the next few months.

18           Who is responsible for designing and evaluating  
19 the project? Is it the contractor or is it the RMP? The  
20 hardware orientation is still there. Where can I get money to  
21 buy radios is a common question. And we try to get away from  
22 that.

23           I think the key issue which is coming along now both  
24 in the RMP activities and in the model systems is the matter  
25 of how one values the effectiveness of the system both in

1 terms of the project goals and in terms of its effect on the  
2 rest of the health problem. We have been working rather hard  
3 in this area with our Office of Planning and Evaluation here.

4 The National Center for Health Services R&D has  
5 stimulated a fair amount of interest in their staff in this  
6 area. And, of course, there is a major requirement for  
7 evaluation techniques of this sort in the model systems.

8 DR. SCHMIDT: Are there any questions or comments in  
9 this area?

10 DR. SCHERLIS: Are future requests for Emergency  
11 Medical Service funds as they come from the individual regions  
12 being looked at by your group or are they being looked at as  
13 part of the general review mechanism without input from your  
14 group? How are these to be considered?

15 DR. ROSE: There are some in the present cycle. We  
16 are trying to pick them out for our own interest, but they are  
17 being thought of at least by us as another activity of the  
18 RMP in no way separate or distinct from their other activities.

19 DR. SCHERLIS: In short, are you including in any of  
20 the data which we have specific evaluation by yourself as  
21 far as the EMS proposals as they come in from individual  
22 regions at the present time?

23 DR. ROSE: No. There may be staff input just as  
24 there might be for any other kind of activity, but there is  
25 no specific EMS-related input which is included because it is

1 EMS. There is no such.

2 DR. SCHERLIS: There are no earmarked funds, I assume,  
3 then at this particular time. This is just that one go-around,  
4 is that correct?

5 DR. ROSE: Yes.

6 DR. SCHERLIS: They come in as part of the total  
7 overall requests.

8 DR. MARGULIES: Correct.

9 MR. HILTON: Len's question raises a point that is  
10 precisely what I wanted to ask with regard to the EMS. Is that  
11 floated in exactly the same way?

12 DR. HINMAN: Yes, it is.

13 DR. SCHMIDT: Are there other questions or comments?

14 DR. SLOAN: Would you like to mention the conference  
15 with the American Heart Association on emergency care of  
16 cardiac patients?

17 DR. ROSE: No more than I guess just to say I am not  
18 as up on that as I should be. There is interest in a conference.  
19 There is to be a conference which I believe is May.

20 DR. SCHMIDT: Dr. Sloan, would you care to comment?

21 DR. SLOAN: Well, the American Heart Association  
22 asked us to cooperate with them in development of a conference  
23 on the emergency handling of cardiac patients in relation to  
24 our interest, the RMP interest, in general emergency medical  
25 services. And I think it is just worthwhile to note that we are

1 trying to cooperate with them and that such a conference will  
2 be held, the proceedings of which will be made available to  
3 all Regional Medical Programs.

4 DR. SCHMIDT: We have learned in Illinois through a  
5 disastrous train wreck, two airplane crashes and Florida  
6 recently learned that the real trick in this whole area is  
7 to have the emergency occur where you can handle it. And if  
8 that doesn't work, you are out of business.

9 Len wanted to say something.

10 DR. SCHERLIS: I was going to ask in reference to  
11 Dr. Sloan's statement if the interest to RMP extends, I would  
12 hope, to participating in the financial support of this  
13 conference or is it as one of the many agencies, and there are  
14 many, which are listed as cooperating in this conference?  
15 It is an important one. It is for emergency cardiac care. It  
16 is being held at the National Research Council much like the  
17 earlier one was several years ago when CPR was stressed. This  
18 is for total early care.

19 Have you been asked for financial support?

20 DR. MARGULIES: I don't know that we have been asked,  
21 Len. I am not sure.

22 I understand we have not.

23 DR. SLOAN: The AHA has a sufficient appropriation.

24 DR. MARGULIES: We have, as you know, a continuing  
25 and to be renewed major contract activity with American Heart

1 Association. So if they need funds, they know the channels.  
2 And if we haven't heard from them, I assume they can do for  
3 the moment without us.

4 I would also assume from that they have something  
5 else in mind later.

6 DR. SCHMIDT: Well, Bill Hilton mentioned PSROs, and  
7 this stimulated our thought that there is something going on  
8 in this area. And Dr. Margulies perhaps could comment on the  
9 H.R. 1 type of activities with PSROs and even perhaps the  
10 kidney problem.

11 DR. MARGULIES: Let me take those in reverse order  
12 for the moment. I suppose that we will forever refer to what  
13 really has another title as H.R. 1. As I recall, it is 92-607  
14 or something of that kind. But H.R. 1 is a catchy title.

15 That, as you know, is the very, very large and  
16 complex series of amendments to the Social Security Act. And  
17 it includes some striking new activities, the full extent of  
18 which is still to be realized. One of them had to do with a  
19 new method of reimbursement for the services required for  
20 individuals requiring dialysis and transplant. This is designed  
21 in such a way that the source of funding for the payment of those  
22 critical services will be relatively ample compared with the  
23 way it has been up to the present time.

24 As I recall, that becomes effective, is it, April 1,

1 DR. HINMAN: July 1.

2 DR. MARGULIES: And it is at the present time being  
3 worked out by the Social Security Administration.

4 What we are hoping for, and we have had good coopera-  
5 tion up to the present time from the National Kidney Foundation,  
6 from the people in NIH, from Social Security, from CHP and  
7 others, is the recognition by those who must reimburse for  
8 payments of the need to identify those settings for dialysis  
9 and transplant of patients where the quality of care can be  
10 well attested to.

11 There is always a risk when something can be paid  
12 for that there will be people available to provide the service  
13 because it could be paid for rather than because they are  
14 expert at it. That is not a pejorative statement aimed at  
15 the profession; that is a sort of general human reaction.

16 In this particular case, it is urgently important  
17 that the institutional setting -- and by that, I mean broad  
18 institutional setting -- in which patients are to receive  
19 dialysis leading to transplant or without transplant, be well  
20 identified, well qualified, and that reimbursement be limited  
21 to those situations where the patient will get the best  
22 possible care without interfering, of course, with his access  
23 to care.

24 It fits in extremely well with our own plans for  
25 developing dialysis in transplant centers through a national

1 kidney network which has been making good progress. We have  
2 been meeting regularly with the people in SSA. And at the  
3 present time, I feel quite encouraged that through a combina-  
4 tion of the various Federal agencies and the professional bodies  
5 which are involved, we will come out with something which  
6 represents both access to patients and protection of patients  
7 with assurance that they will get good quality care. But the  
8 final definitions have not been reached.

9           On the subject of PSRO, let me just spend a few  
10 minutes on that one because it is an extremely important subject  
11 and one which the whole health community is interested in and  
12 so also are patients or certainly organized consumer groups.

13           It is essentially a proposal which was known usually  
14 as the Bennett Amendment which states that there must be a  
15 mechanism associated with Social Security-SRS reimbursement  
16 mechanisms to give assurance that the quality of care which  
17 is being provided meets acceptable standards. And for that  
18 purpose, it was agreed that there should be established what  
19 has already been described as a Professional Standards Review  
20 Organization which has been very, very broadly described in the  
21 legislation.

22           The main elements of it which are clear at the  
23 present time are that the initial phases of this kind of  
24 quality assessment and assurance will be confined to institu-  
25 tional settings which means hospitals, intermediate care

1 facilities, and nursing homes; that there will be a total  
2 dependence upon a peer review mechanism, but with full access to  
3 this peer review mechanism on the part of all major providers  
4 of medical care.

5           The circumstances in which a PSRO organization  
6 will be established need to be described so that there is a  
7 long series of regulations which must be written. They will,  
8 as presently planned, consist of opportunities within States  
9 and within portions of States for professional groups to  
10 establish peer review organizations which will then set some  
11 kind of criteria, measure performance against those criteria,  
12 and use these as a basis for giving assurance to the public  
13 that the quality of care they receive is what it should be with,  
14 of course, the controlling element being reimbursement for the  
15 services being provided.

16           The present state of development of that consists  
17 approximately of the following: The Office of the Assistant  
18 Secretary for Health -- Incidentally, that is a new name for  
19 the position which Dr. DuVal was occupying. It was Health  
20 and Scientific Affairs. It is now Assistant Secretary for  
21 Health. There has been a new description of the position in  
22 the Federal Register with a fuller understanding of what their  
23 function is. The basic responsibility for the development of  
24 the PSRO lies in that office.

1 a couple of days so I don't know if it is completed -- I think  
2 I would have heard if it had been -- the search for a director  
3 for the PSRO activity who will be located within that office.  
4 It will then from the Federal point of view be necessary for a  
5 number of activities to be carried out which range all the way  
6 from the establishment of a National Council for PSRO to the  
7 definition of what the PSRO is to do, to the establishment of  
8 regulations, to the creation of reimbursement mechanism  
9 through the Social Security Administration, to the establish-  
10 ment of a range of technical and professional advisory functions  
11 which will have to be carried out within and outside of  
12 government.

13 From the HSMHA point of view, there has been  
14 established within the agency a group of people to work on PSRO  
15 as a general activity for us to understand more fully and to  
16 allow programs to be as prepared as they can be for whatever  
17 responsibilities they are given.

18 There has been no explicit assignment of responsi-  
19 bilities excepting for preparation for whatever support the  
20 Department is going to need when it does make its assignments.  
21 Within HSMHA it is organized as follows:

22 One individual who is one of the Deputy Administrators,  
23 Emery Johnson, is the key person involved in the PSRO activities.  
24 There is, then, an agency-wide coordinating body which  
25 represents a number of programs, including RMP, National Center

1 for Health Services R&D, which has basic quality R&D responsi-  
2 bilities, Community Health Services, National Institute of  
3 Mental Health, and so on, which are all on this PSRO coordinat-  
4 ing committee.

5 It also has an executive committee on which I sit as  
6 the Director of RMPS which includes some of the same groups I  
7 just mentioned -- NIMH, the Office of Planning and Evaluation,  
8 National Center for Health Services R&D, Community Health  
9 Services. They have associated with them a working task force.

10 Now, this executive group and the coordinating  
11 committee and the task force are working very closely both with  
12 the Department and the Social Security Administration as we  
13 begin to develop an understanding of what a PSRO prototype  
14 would be, what the elements would be, how criteria are to be  
15 established, what kind of continuing education will be  
16 required.

17 We have also primarily on the urging of RMPS, R&D  
18 and CHS, been asking groups outside of government to come in and  
19 share with us their own interests and their own activities.  
20 And we are going to set up a series of such meetings so that we  
21 can make sure that the interests of the American Hospital  
22 Association, the American Medical Association, the foundation  
23 groups, etc., are involved. And we see -- and this is really  
24 a judgmental statement rather than a bureaucratic one -- a  
25 great responsibility on the part of the Government to assist

1 the health activities, the organized health activities, outside  
2 of government to act together to coordinate their activities  
3 rather than to go about it separately even when they are not in  
4 conflict. Because if there is dysjuncture between groups like  
5 AMA, American Hospital Association, foundation groups,  
6 associations of medical clinics, and so forth, it will be to  
7 everybody's disadvantage and certainly will not help to  
8 develop an effective PSRO structure.

9           So far we have been deeply encouraged by the great  
10 willingness of groups to not only come in and share their  
11 interests with us, but to join their organizational peers in  
12 meeting together.

13           At the same time, I rather suspect that some of those  
14 same groups are going to have to help us from the outside  
15 coordinate our activities.

16           Generally speaking, as a kind of a basic principle  
17 which Peters has not approached so far as I know, bureaucracies  
18 can be organized better from pressures from outside than they  
19 can by energies from inside. You may quote me on that. So we  
20 will look to those outside us to bring us together, and we  
21 will look at ourselves to bring them together. And I think  
22 that the prospects are very good. It is hard to predict what  
23 the actual impact of PSRO activities will be.

24           Two or three things are clear. There will have to be  
25 developed data and information systems which serve not only

... 1 existing utilization review, but also PSRO activities and as  
2 well the kinds of basic informational demands for health  
3 services which Veronica Conley was referring to when she was  
4 talking about the health educational activities.

5 We must have a common, well-defined, consistent  
6 source of data which can serve planners, which can serve PSRO,  
7 utilization review, and do it in such a way that we know what  
8 we are talking about or at least we are all looking at the  
9 same set of data rather than at a whole range of incompatible  
10 data which mean whatever you think they mean at the moment.

11 There is real movement in that direction. And I  
12 think that SSA is going to help a great deal as will be the  
13 rapidly expanding Federal-State-local health data system which  
14 is emanating from HSMHA.

15 Secondly, it is clear that there has to be a continuum  
16 and a linkage between utilization review as it is presently  
17 carried out in institutions and the PSRO activities which have  
18 to do with the quality of services which are being provided.

19 And, third, there is limited, very limited, recogni-  
20 tion of the need to be prepared to do something about what it is  
21 you are discovering when you carry out this kind of a review  
22 activity. There is an almost reflex tendency on the part of  
23 the inexperienced dealing with PSRO to speak in terms of  
24 sanctions against those institutions or individuals who don't  
25 come up to the mark as though the only solution if someone

1 does poorly is to cut them out of the system. This is clearly  
2 not our intent. And it won't work in any case.

3           The real problem will be not only to develop effective  
4 information systems which certainly have to include a revolution  
5 in medical records and standards of reference and comparisons  
6 between performance and those standards, but some techniques  
7 for remedying what is found wrong. And the responsibility for  
8 doing that will certainly include Regional Medical Programs,  
9 not only in the kinds of educational activities with which we  
10 have some familiarity, but some organizational improvements, some  
11 manpower extension activities, some improvements which overcome  
12 the problems of deficiencies in services due to shortages or  
13 maldistribution of health manpower. And of all of the  
14 activities in PSRO, it seems to many of us that the remedial  
15 aspects of this have been least attended. They will be addressed  
16 not in the PSRO structure, but as broad issues which are  
17 important in any setting at the St. Louis conference, but I have  
18 the feeling that we will do less well on that subject than on  
19 a good many others that we are going to be considering.

20           I think there is little doubt, for example, that  
21 there will have to be rapidly heightened, even above the present  
22 pace, attention to sensible, logical, recordable, transferrable,  
23 medical record systems which can be used for audit purposes.  
24 And this in itself is an undertaking of no mean proportions.

25           So what is happening is a rapidly growing response

1 on the part of Government to legislation which was passed very  
2 late in the last session of Congress, but which must become  
3 effective by January 1. So that the time involved is very,  
4 very brief.

5 DR. HESS: I wonder if you could comment a little bit  
6 more on what is going on in the area of medical records because  
7 this is of extremely critical importance in this area.

8 DR. MARGULIES: Well, in RMPS, but certainly outside  
9 of it, there is a crescendo of interest even above what it was  
10 a year ago in the problem of oriented medical records.  
11 Recently a conference that Willis Hurst held down in Atlanta  
12 had a huge attendance on the part of people who realized that  
13 this may very well be the best available kind of record system.  
14 We see growing evidence around the country of hospitals, of  
15 groups of people, beginning to recognize the fact that there  
16 must be a rapid change in medical record systems. I don't  
17 believe that this agency or SSA has recognized a need to put  
18 official pressure behind the development of that kind of a  
19 medical record system, but it would not surprise me if that  
20 kind of thing should occur.

21 I know that Representative Rogers has been strongly  
22 tempted to introduce legislation requiring that kind of a  
23 medical record system which I think would be most unfortunate.  
24 I would prefer to see the profession reach in that direction.

25 We have not, however, and this concerns me, been

1 able to reach a conclusion in this agency that we should take a  
2 position and promote a kind of medical record system at this  
3 time. I am impatient with the tendency to continue to research  
4 and wonder and study on something which at least is well  
5 enough established so that it would be a vast improvement over  
6 the kind of patchwork we have at the present time. I would  
7 like to see us come to the conclusion saying this or that.

8 I don't know if anyone is going to have courage  
9 enough to require under PSRO at the central level a medical  
10 record system of a specific kind, but I rather suspect that  
11 a good many of the early developments in PSROs where the  
12 progress has already been great are going to come to that  
13 conclusion right at the beginning this will be the only medical  
14 record system acceptable. But the action is general and not  
15 coordinated.

16 MISS ANDERSON: Dr. Margulies, I know it is hard to  
17 mention all the names of people involved in this planning, but  
18 are allied health groups or nursing groups involved in this  
19 initial planning phase?

20 DR. MARGULIES: You mean within the Department?

21 MISS ANDERSON: Well, planning for this national  
22 council. You talk about the AMA and Hospital Association and  
23 so forth. I was wondering about the nursing association or  
24 the allied health group.

25 DR. MARGULIES: Well, the question is how extensive

1 has been our involvement in bringing in groups to work with us.  
2 We have only just begun. This particular PSRO activity is not  
3 more than 6 or 8 weeks old. And so we have actually been  
4 responding initially to those who have come to us with some  
5 interests of their own.

6 For example, the QAP of the American Hospital  
7 Association was of immediate and early interest as has been  
8 the Social Security Administration. And we had already been  
9 working with the National Kidney Foundation. But we will  
10 certainly find it necessary to work with those other kinds of  
11 professional groups like nursing associations, allied health,  
12 where there has been developed an approach and some under-  
13 standing or where there is a need for it in establishing the  
14 PSRO.

15 Even though it is keyed very clearly in the legisla-  
16 tion around the physician peer review mechanism, it should be  
17 self-apparent that PSRO as it is going to develop will require  
18 an effective review for those who provide medical care which  
19 means a small minority of physicians and a great majority of  
20 others.

21 And I should mention one other thing that although  
22 the legislation require-s PSRO in the institutional setting,  
23 it does allow room for some experimentation and some early  
24 entries into the ambulatory care delivery system with the  
25 implication that as PSRO develops in the institutional setting,

1 it will be expanded out of that and into the ambulatory delivery  
2 environment.

3 Now, that was a decision made for practical reasons.  
4 It is tough enough to do it in the institutional setting. And  
5 the feeling was we really aren't ready to try to take on the  
6 ambulatory PSRO type of thing. And in fact, if you reflect  
7 on it for a moment, the institutional setting sounds tough  
8 when you think of hospitals and agonizing when you think about  
9 nursing homes.

10 We have somehow or other never gotten ourselves to  
11 really talk seriously about PSRO in nursing homes. I think  
12 everyone is well aware of the fact that that is a very, very  
13 difficult field.

14 DR. ANCRUM: Dr. Margulies, for the institutional  
15 settings, isn't that only if they are involved with reimburse-  
16 ment for Title XVIII and XIX? I am thinking about an institutio  
17 may not want to come in. Do they have that choice?

18 DR. MARGULIES: This is based around the Social  
19 Security amendments. That's right. What usually happens,  
20 however, and it doesn't take very long, is that all third  
21 party carriers fall into the pattern of what has been establish  
22 through SSA. So that it would seem to me highly unlikely that  
23 other methods of reimbursement would remain isolated from the  
24 PSRO activity if it appears to be a method of giving warranty  
25 of good quality care to the public which is being served.

1 But it is a requirement only under what used to be  
2 known as H.R. 1.

3 DR. SCHMIDT: All right. Thank you.

4 Are there other questions or comments?

5 Yes, Dr. Brindley.

6 DR. BRINDLEY: Not specifically related to that.

7 This may not be appropriate, but where do we stand on HMOs  
8 as far as RMPs is concerned?

9 DR. MARGULIES: The question is on HMOs.

10 This is a great morning. How do you think those  
11 things up?

12 Well, as you recall, the legislation for Health  
13 Maintenance Organizations did not pass during the last session  
14 of Congress. As a consequence, there is nothing officially  
15 known as HMO. The RMP funds which were used during the last  
16 fiscal year went to some 29 HMOs which were in developmental  
17 phase. There is no more RMP money identified for that purpose.  
18 There will be no funds used for operational support of HMOs.

19 There is a hope, of course -- and again Mr. Rogers  
20 has indicated his interest in it -- that the Health Maintenance  
21 Organization legislation will pass very rapidly. There then  
22 will be appropriations. And in those circumstances, it will be  
23 existing as a separate, self-sustaining activity in which the  
24 RMP interest will be only as it is appropriate to the RMP  
25 mission.

1 I think that the kinds of conduits which were used  
2 in the past for this will either no longer be necessary because  
3 the HMO activity fails or no longer necessary because it  
4 succeeds and has its own independent appropriation.

5 DR. SCHMIDT: Other comments?

6 MR. TOOMEY: Dr. Margulies, what has been considered  
7 in terms of the composition of the membership of the PSRO?

8 DR. MARGULIES: At the State, you mean, at the local  
9 level?

10 MR. TOOMEY: State or local.

11 DR. MARGULIES: Well, that is described again  
12 rather loosely in the legislation. It must include -- and I  
13 don't know the exact terms, perhaps someone else here does --  
14 physician representation which is not limited to M.D.s. We  
15 are talking about M.D.s, osteopathic physicians and other health  
16 care providers. It cannot be designed, for example, around a  
17 county medical society because that is a selected group. If  
18 you have to be in a county medical society to be in the PSRO,  
19 then that is not an acceptable PSRO arrangement.

20 On the other hand, members of county medical  
21 societies can make up PSROs as a separate activity.

22 The intention, as the language was developed and as  
23 it was understood in the Department at that time, was to give  
24 the PSRO governance a very broad base which would mean that  
25 it would represent quite frankly the best description of a fairly

1 characteristic PSRO base as Dr. DuVal was understood at the  
2 time it was passed was a good regional advisory group of an  
3 RMP, a good many health care providers, people representing  
4 institutions, allied health, and some consumers. But it is not  
5 really a consumer-oriented thing. It is a provider-oriented.  
6 And in the final analysis, it is the physician peer review  
7 mechanism which dominates in the legislation and in the manage-  
8 ment of it.

9 And as I recall, the National Council is an all-  
10 physician group. Is that right, Bob?

11 MR. MORALES: There is a requirement to include other  
12 providers such as nurses and that type of officials.

13 DR. MARGULIES: It was designed in such a way that  
14 it would not become the private fiefdom of physicians.

15 MR. TOOMEY: Will foundations be able to move in as  
16 a PSRO without changing the composition and foundation and  
17 board itself?

18 DR. MARGULIES: I would say yes to the first part  
19 that the foundations will very likely not only be able to move  
20 in, but they are likely to be early beginnings in PSROs.

21 I suspect that a good many of them will have to  
22 change their structure in some way because they tend to be  
23 restricted to physicians and will have to embrace a larger  
24 group of individuals involved in health care provision. But  
25 that is the kind of thing which regulations will have to be

1 written to to identify. And I could be wrong on that.

2 DR. SCHERLIS: In its broad phase, can this get  
3 involved initially with categorization of facilities as it  
4 sets up professional standards or is it looking at individual  
5 rather than group service?

6 DR. MARGULIES: The question is could this get  
7 involved in categorization of institutions. I think the answer  
8 to that is probably yes, depending upon, again, interpretation  
9 and regulations. But one of the aspects of the PSRO is  
10 institutional quality review which is again almost self-  
11 evident. One can hardly expect a group of health care providers  
12 to meet a standard of performance in an institution which does  
13 not. And certainly, if a hospital is to be utilized, there must  
14 be evidence that it meets some kind of quality criteria for  
15 its own diagnostic and care facilities.

16 When we began to think about our own Section 907  
17 activities which I will remind you of in a moment, we realized  
18 that these needed to be moved into the PSRO environment for  
19 our own group to look at. And we are going to be doing that.

20 Now, the Section 907 activity is one which has grown  
21 out of the original legislation through which RMP was established.  
22 You may recall that it is a section which says that at that  
23 time, the Surgeon General, now the Secretary, will publish  
24 a list of hospitals which have the most advanced facilities  
25 for health disease, cancer, and stroke, and then later kidney

1 disease was added. We are currently in the late phases of a  
2 very vigorous contract carried out with the Joint Commission  
3 for the Accreditation of Hospitals to establish some kinds of  
4 criteria which conform to the current intent of that section.

5           What has been done is the distribution of a very  
6 complete questionnaire to hospitals all over the country with  
7 a remarkably good response which will allow us to identify  
8 hospitals in accordance with their capacity to deal with  
9 heart disease, cancer, stroke, and kidney disease.

10           It will also allow us to establish a kind of tier  
11 of quality which could roughly, depending upon how it finally  
12 evolves, identify institutions which are able to do the most  
13 sophisticated referral type of activity, a good example being  
14 transplant of kidneys or chemotherapy which can be done only  
15 under very specialized circumstances for patients with cancer  
16 and so forth, the so-called tertiary institutions. We should  
17 be able to identify the criteria and perhaps the institutions  
18 meeting those criteria for tertiary care, for secondary care --  
19 that is, institutions which are able to accept referral  
20 patients, not necessarily for the most advanced, but for some-  
21 thing which requires referral -- and other hospitals which are  
22 adequate for primary purposes.

23           Now, if the PSRO is designed around the medical  
24 care system of a region, of part of a State or all of a State,  
25 then the identification of institutions which are competent to

1 do some kinds of things and apparently not to do others would be  
2 of real value in trying to set up criteria for performance and  
3 in trying to identify where therapy, where diagnosis and  
4 treatment should be carried out and what the resources are for  
5 better teaching and for systematic regionalization of health  
6 care delivery systems. This, of course, would mean that  
7 they would be linked in closely with planning agencies. And  
8 we propose to utilize this list of criteria in hospitals so that  
9 planning agencies will be able to take advantage of them as  
10 well.

11 I rather suspect that PSROs could if they wished to,  
12 Len, use this kind of thing and decide whether they want to  
13 enter into that kind of definition of where a particular service  
14 should be provided and where it should not. You can easily  
15 appreciate the hazards which are involved in that decision, but  
16 in some cases the hazards would certainly not be great.

17 It would not be difficult for a PSRO to say that this  
18 institution is not prepared to take on open heart surgery and  
19 this one is. The gross distinctions would be relatively simple.  
20 It may get a little tougher if you try to make decisions about  
21 where you can manage a patient with an initial infarction who  
22 is already in congestive failure or something of that kind.  
23 It is a little bit more doubtful. But you have no difficulty  
24 in distinguishing between a small primary hospital and a  
25 secondary referral hospital in that case.

1 I would suspect they would want to take advantage of  
2 it if they are imaginative and aggressive. But the  
3 decision will be theirs.

4 MR. TOOMEY: I believe the legislation also said  
5 that if you have an adequately functioning utilization review  
6 committee within the institution, that this can act as a PSRO.  
7 Has your group given any consideration to this particular  
8 situation? And what is an adequately functioning utilization  
9 review committee?

10 DR. MARGULIES: The question, if you couldn't  
11 hear it, is related to the fact that the legislation indicates  
12 the acceptability in hospitals of existing utilization review  
13 activities.

14 When the Administration was preparing its own  
15 position on H.R. 1, it expressed its skepticism regarding  
16 existing utilization review activities throughout the country.  
17 There will be no objection to the use of existing UR activities,  
18 but there will be considerable doubt about whether they could  
19 do the PSRO kind of activity if their performance with the  
20 utilization review is a criterion of what would happen under  
21 PSRO.

22 I think as a matter of convenience, what they are  
23 saying in this is there will be increased attention and demand  
24 to both utilization review and PSRO. And since they will be  
25 dealing with the same patients and same kind of information

1 systems, it is reasonable that that be an element in the PSRO.  
2 But I rather suspect regulations will require something more  
3 than what has been established for utilization review up to the  
4 present time.

5 And there is concern with those who are working on  
6 it that the use of the utilization review mechanism might tend  
7 to restrict what happens to utilization review rather than  
8 really get into issues of quality which are not the same  
9 issues. I think that, however, you have touched on something  
10 which is as likely to be a difficult issue as any in the whole  
11 process.

12 MR. TOOMEY: Because there is a tremendous opportunity  
13 for conflict within the medical profession itself. Of course,  
14 the American Hospital Association is pushing its QAP, Quality  
15 Assurance Program, to be melded into the utilization review  
16 simply to allow for the physicians who are using the institution  
17 to continue not only to evaluate the quality of care, but also  
18 the utilization of the institution or vice versa.

19 DR. MARGULIES: I think it would be unwise where there  
20 is an effective utilization review activity to set up another  
21 and parallel activity. That should be the core of it. But it  
22 should not be restricted to that core. That is the problem.

23 MR. TOOMEY: That is why they are going into the QAP.

24 DR. MARGULIES: I think the QAP makes very good  
25 sense.

1 MR. CHAMBLISS: Does this not, Dr. Margulies, require  
2 the expansion of the review utilization committee? It has been  
3 pretty well a hospital-related function.

4 DR. MARGULIES: I think so.

5 DR. JAMES: May I make a comment along that line?  
6 When you mentioned earlier regarding standards for hypertension  
7 in terms of perhaps the nation has come to the point now  
8 where it could set up standards for the adequate treatment of  
9 patients, I think that is the way I understand it. It seems  
10 to me like while we are talking about utilization and quality  
11 control, where are the standards for good medical care as you  
12 would see them related to the total program?

13 DR. MARGULIES: One of the responsibilities of the  
14 Department will be to guide the way toward the development of  
15 what will be effective standards. There will be two issues.

16 One of them is the creation of acceptable standards  
17 which represent a professional output like those that we have  
18 done, say, through the Inter-Society Commission on Heart  
19 Disease Resources or through the National Kidney activities,  
20 the things we are doing with stroke and so forth. And there  
21 aren't enough of them. We need more of them. And we are  
22 developing some contracts in RMPS and also in HSMHA to move in  
23 that direction.

24 But the other and thorny part will be to see what  
25 the relationship is between those kinds of general standards

1 and local concepts of practice. The PSRO, I suspect, will be  
2 asked to develop its criteria, but it is going to be looked at  
3 very carefully to see how it goes about that.

4 . Those who are being critical of the profession are  
5 afraid that a development based upon local standard setting  
6 will be established at a point of kind of mutual self-protection  
7 instead of aiming toward high quality. I think people who  
8 say that are being a little foolish. Our experience has been  
9 that those who step aside from their practice to work toward  
10 the establishment of criteria which they think they should  
11 meet tend to set them too high -- actually higher than they  
12 can achieve. Because when they get away from day-to-day  
13 practice and say, "What should I be doing for the identification  
14 of a patient for a tonsillectomy or eye surgery or whatever,"  
15 they tend to become a little textbookish rather than practice  
16 oriented.

17 But the real question, and I think the profession is  
18 going to have to play a very, very alert part in this, is the  
19 translation from national standards to local practice or local  
20 circumstances. And I would like to just say on this subject  
21 in general that if ever there was a time for the health  
22 professions to meet a responsibility which is probably the  
23 most important individual responsibility they can possibly meet,  
24 it is in this one subject.

1 England to compare the health delivery systems of the United  
2 Kingdom, Canada, and the United States. And one of the issues  
3 we dealt with was quality assessment. And it was apparent that  
4 when other countries, including Sweden and some of the eastern  
5 countries, began to look at the United States in this subject,  
6 they agreed at that conference, the people from the other  
7 countries, that we do far more at the present time without  
8 PSRO, without utilization review and so forth, to measure the  
9 quality of medical care than do any of the others. They don't  
10 have tissue review committees, they don't have record review  
11 committees, they do relatively little both in Canada and the  
12 United Kingdom, and that includes Sweden as well. We are well  
13 ahead of them.

14 But now they are looking to see what we are going to  
15 do, what the profession is going to do -- and this is really  
16 a professional issue -- to prove its basically conservative  
17 professional character which is to protect and promote the  
18 quality of medical care.

19 Now, there has never been within the profession any  
20 dissention over whether this is an acceptable and basic purpose  
21 in what we do. In fact, the whole issue, everything we talk  
22 about in the Federal Government and outside of it, comes down  
23 to the question of whether medical care is of good quality,  
24 whether you are talking about the how many people or what is  
25 done with the individual. And this is the time when we could

1 not only evaluate practice here and make a difference in the  
2 whole professional environment, but set a pattern for the whole  
3 world. Because if what we can achieve can be done effectively,  
4 it will influence the practices in Canada, in Western Europe,  
5 in Eastern Europe and, of course, throughout the rest of the  
6 country. It is being looked at with great, great interest.  
7 And as it develops to a higher level, it is going to set the  
8 pace for generations to come.

9 If it fumbles, if it is not done effectively, somebody  
10 is going to come along with some kind of further regulation  
11 which is not as good. I think it is an exciting time, but I  
12 think very few people realize the full involvement, the full  
13 difficulty, which it presents.

14 DR. SCHMIDT: I think you have given us a logical  
15 break point. The next activity will be to synchronize watches.

16 It is approximately 25 minutes to 11. And we will  
17 now break and reconvene not later than 10 minutes to 11.

18 (Whereupon, a recess was taken.)

19 DR. SCHMIDT: We still have a couple of items to  
20 cover. We have talked a little bit about revenue sharing and  
21 the subject of sharing of authority and responsibility is  
22 something very much being discussed in a number of areas. We  
23 mentioned the sharing of decision-making and priority-setting  
24 and so on that will be going on as part of future developments.  
25 And the next agenda item really kind of can be umbrellaed by

1 that general topic.

2 We all have been told from time to time and have  
3 been briefed on the activities having to do with the  
4 individual RMP review process and what have been called verifi-  
5 cation visits to regions, looking at specifically their review  
6 and decision-making processes. And Mr. Chambliss is going to  
7 tell us a little on how that has been going.

8 MR. CHAMBLISS: About a year ago, RMPS developed a  
9 document in response to recommendations from the FAST Task  
10 Force, entitled "RMP Review Process Requirements and Standards."  
11 And this document set forth the requirements for the decentrali-  
12 zation of project review and the decentralization of funding  
13 authority to the RMPs.

14 A handbook was produced setting forth certain  
15 definitions and certain requirements in this area. And the key  
16 issue was to have the regions abide by certain standards that  
17 would make for overfunding decisions and having to do with the  
18 technical adequacy of proposed operational projects and also  
19 those activities which were funded within the approved amount  
20 of the grant award.

21 There were minimum standards set forth on review  
22 criteria and program priorities, on staff assistance, on CHP  
23 reviewing comment, technical review, project arranging and  
24 funding, feedback, and appeal procedure.

25 Now, during the past year, the Division of Operations

1 and development staff has set a goal of visiting to certify  
2 or to review the verification processes of all of the 56 RMPs.  
3 During the year, then, 51 of the 56 RMPs have in fact been  
4 visited. Five regions were not visited, and those five regions  
5 are California, Arizona, Northeast Ohio, South Dakota and  
6 Delaware. There were specific reasons why these regions could  
7 not be visited within the specified time.

8 In the case of California, there were tremendous  
9 logistical problems that you could well imagine there. The  
10 staff is now planning to make that visit soon. As you can  
11 appreciate, there will probably be a period of two weeks that  
12 the staff will have to be in California looking at the 9 areas  
13 of that RMP.

14 There were other technical problems having to do with  
15 Arizona, Northeast Ohio. And in the case of South Dakota and  
16 Delaware, those two regions are still in their planning stages.

17 Now, of the 51 Regional Medical Programs visited --  
18 and I might say it has taken a yeoman effort on the part of staff  
19 to get these visits in within the prescribed time -- there has  
20 been unusual staff cooperation between the components of RMPS  
21 and I should say here and now before the committee, before the  
22 staff and the public, that the support given the Division of  
23 Operations and Development by Planning and Evaluation and by  
24 the Division of Professional and Technical Development has  
25 been very noteworthy. Of the 51 regions visited, and I might

1 say that these regions are, as you know, organized along the  
2 desk structure, the Eastern Operations Branch having 20 regions,  
3 the South Central Branch having 16, the Mid-Continent Operations  
4 Branch 14 regions, and the Western Operations Branch 6 regions,  
5 including California -- that of the 51 visited, 36 regions  
6 have been fully approved or certified to date. There are 15  
7 regions which have been provisionally certified or which have  
8 been disapproved due to substantive shortcomings in applying  
9 the standards. And as a consequence, staff is working with  
10 those regions very closely in seeing that whatever the  
11 deficiencies or whatever the bases for disapproval are cleared  
12 up.

13           You would like to know that most of these visits  
14 have been made in the last six months, and the nearest being,  
15 of course, Metro Washington and the furthest away being Hawaii.  
16 And I think you would like to know that one of the visits was  
17 made at 27° below 0°. So you can get a vision of the zeal and  
18 enthusiasm that our staff has had in carrying these out.

19           But in some, we would say that we proposed to finish  
20 up the remaining visits within the next two months and will  
21 give you a report on that activity later.

22           DR. SCHMIDT: I am sure that some of the visits must  
23 have generated some heat.

24           MR. CHAMBLISS: They did indeed.

25           DR. SCHMIDT: The general topic, though, is kind of

1 an interesting one. And I was musing in the last few days  
2 as to whether or not this report would generate any discussion.  
3 So now I am going to find out.

4 Is there any discussion?

5 MR. TOOMEY: What were the shortcomings you found?

6 MR. CHAMBLISS: The shortcomings? We have undertaken  
7 a study of this, but many times the application may not meet  
8 the criteria set forth in the standards or maybe there was  
9 improper or incomplete review and comment by CHP agencies.  
10 Many times, the priority ranking system was not adequate to  
11 ensure that the proper funding decisions could be made in  
12 keeping with the criteria. Occasionally, we found there was  
13 inadequate feedback to the applicant who had not been successful  
14 in having his proposal funded. So there were a number of  
15 reasons why they did not meet the review criteria.

16 MR. TOOMEY: When you disapprove them, what happens?

17 MR. CHAMBLISS: Generally, the region is told what the  
18 basis for the disapproval is. It is itemized. And then if it  
19 is a technical disapproval, we attempt to give the region a  
20 time in which to meet that particular standard. And the staff  
21 usually works very closely with the region in trying to overcome  
22 that.

23 MR. TOOMEY: Have you had enough time to see how  
24 quickly they attack these shortcomings that you have pinpointed?

25 MR. CHAMBLISS: We have been most pleased with that.

1 Just this week, we had three responses from regions saying that  
2 the technical basis for the disapproval had been overcome. So  
3 they are closing those deficiencies as much as possible.

4 Now, there are some with more substantive bases for  
5 disapproval. And the staff is working with them much more in  
6 detail.

7 MR. TOOMEY: Do you find at all they will disagree  
8 with your judgment?

9 MR. CHAMBLISS: This has been a very interesting  
10 phenomenon. Many times the region has said to us, "We agree  
11 with the bases," because it has given them an opportunity to  
12 strengthen some of their internal procedures. Occasionally we  
13 have had a region somewhat disagree, but in the process of  
14 discussion and negotiation, those have been overcome.

15 DR. LUGINBUHL: Could you give us an example of one  
16 of their substantive problems?

17 MR. CHAMBLISS: One of the substantive problems had  
18 to do with CHP relationships and review and comment and  
19 especially in one of our regions under the Mid-Continent  
20 Operation Branch.

21 DR. SCHMIDT: First, Judy, did you have a comment?

22 MRS. SILSBEE: I was going to say in answer to Mr.  
23 Toomey's question, our goal is to get all of these regions in  
24 compliance because the stated next step would be to take away  
25 from them all decisions with regard to what the project

1 technical review and funding decisions are. And that is  
2 something that we don't want to take back into Rockville. And  
3 so the incentive on both our parts and regions is quite great  
4 to get these things straightened out.

5 MR. TOOMEY: What happens at the rank level when  
6 you point these things out? Are these people conversant enough  
7 with your operation to understand the deficiency you point out?  
8 Do they have problems?

9 MR. CHAMBLISS: Dick.

10 MR. RUSSELL: I would like to respond to that because  
11 we have had on a couple of occasions going in -- of course, we  
12 do meet with representatives of the Regional Advisory Groups.  
13 And as a result, when we have our feedback session, they seem  
14 greatly relieved in some cases that this has been pointed out  
15 to them. And in some cases, this gives the RAG the clout that  
16 they perhaps have exercised in the past. So they have been  
17 very receptive to the feedback.

18 MRS. SILSBEE: I don't think any of us mean to  
19 imply the millenium is here. These are minimum standards. And  
20 all of the visits have pointed up need for monitoring and kind  
21 of continued seeing how these are working out and whether they  
22 are following them.

23 DR. SCHMIDT: First, Mr. Hilton and then Dr. Thurman  
24 and Dr. James.

25 MR. HILTON: I just had two questions or maybe

1 comments.

2 The procedures manual that was referred to earlier,  
3 does that go into this area of technical review to provide  
4 guidance so that when it is released, we know it is documented  
5 somewhere?

6 MR. CHAMBLISS: Yes, it will contain these standards.

7 MR. HILTON: With regard to the CHP, was staff able  
8 to make any determination as to the degree to which the problem  
9 originated with CHPs understaffing contributing to that and  
10 the other kinds of problems where the RMP might have tried to  
11 make the proper communications with the accepted guidelines, but  
12 couldn't?

13 MR. CHAMBLISS: Mr. Peterson, would you care to  
14 comment there?

15 MR. PETERSON: I think we might say two things about  
16 the CHP review and comment procedure. I think there have been  
17 perhaps three levels or three different kinds of problems we  
18 have seen. Some of them are essentially technical, but some-  
19 times they get beyond the technical problems leading to  
20 emotional stress and strain.

21 There are technical problems relating to a 30-day  
22 requirement and what you give a CHP and whether some things  
23 are being technically complied with. I think in a few of  
24 the regions, at least, that I am aware of, we have sensed that  
25 they really were symptoms of lack of adequate cooperation and

1 understanding, that they were simply the clubs that were being  
2 used in this battle.

3 I think a more substantive aspect of this which really  
4 one in part comes out through the verification visits -- and  
5 I personally only participated, I guess, in three or four and  
6 none within the last six months -- comes to light as a result  
7 of an analysis that my office has done, is in the process now  
8 of getting out, in the way of a program analysis memorandum on  
9 the scope and nature of CHP comments during the first year in  
10 which that was implemented.

11 We required as of the May cycle, 1971, that all RMP  
12 applications, the opportunity for CHP review, a comment be  
13 provided. So we had a year's experience as of this past  
14 summer. And we have been trying to analyze to the extent that  
15 there was written comment letters supplied with the applications,  
16 sort of the nature of those. And I think there are some striking  
17 things that can be said in that regard.

18 First and foremost, I think we find that much of  
19 the CHP comment is of a general nature. They comment on the  
20 application as a whole or the RMP. And it tends to be of the  
21 Good Housekeeping Seal of Approval. It doesn't say much, and  
22 I question it.

23 There is very little CHP comment to date in terms  
24 of specific activities being proposed -- this home care project  
25 or that EMS planning effort. There is some of that, but on the

1 understanding, that they were simply the clubs that were being  
2 used in this battle.

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21 Good Housekeeping Seal of Approval. It doesn't say much, and  
22 I question it.

23 There is very little CHP comment to date in terms  
24 of specific activities being proposed -- this home care project  
25 or that EMS planning effort. There is some of that, but on the

1 whole, it is comparatively small. To the extent it exists at  
2 all, it tends to be favorable.

3 That may simply mean that there are other forms in  
4 writing in which they express themselves unfavorably. But  
5 certainly in discussing these findings with some of the CHP  
6 staff here, I think there is a general agreement that what this  
7 points up is that in most CHPs, whether they are talking about  
8 areawide or State, but principally areawide, there really  
9 aren't the kind of specific priorities or plans that have been  
10 developed yet that permit them to comment in terms of a  
11 particular kind of activity or a specific proposal. And I  
12 think that goes beyond the verification visit process, but  
13 I think it has some implications for CHP review and comment.

14 DR. SCHMIDT: Dr. Thurman.

15 DR. THURMAN: I am out.

16 DR. SCHMIDT: Dr. James.

17 DR. JAMES: I don't know quite how to ask this  
18 particular question related to what you are speaking of, but I  
19 think you mentioned that primarily what was involved had to do  
20 with the decentralization of the review process.

21 MRS. SILSBEE: The technical review, Dr. James, of  
22 projects.

23 DR. JAMES: At the local level. And I wanted a  
24 clarification on that so that I would be sure that I understand  
25 the focus here relative to the larger applications coming into

1 this review committee or is the focus relative to applicants  
2 at the local level in that the local RMP is following the  
3 guidelines? I wasn't quite sure where the focus was.

4 MRS. SILSBEE: Well, the background of this  
5 particular verification was when the FAST Task Force which was  
6 before your time, but it was an organization for streamlining  
7 grant operations and application procedures and so forth,  
8 when they looked at the Regional Medical Programs and saw  
9 what was developing out there -- and this was several years  
10 ago -- it seemed to them that the national review process was  
11 duplicating what was occurring on the local level with  
12 regard to looking at the individual projects, looking at the  
13 technical adequacy of them. They recommended, and Dr.  
14 Margulies implemented, the procedure that the national review  
15 process would no longer do that particular thing.

16 Before your time, this review committee used to take  
17 a project and the applications came in with the full material,  
18 all the background information on a project, and go through  
19 the project and look at it to see if they thought it was  
20 technically adequate and whether the project itself should be  
21 approved or disapproved. This was creating problems since  
22 the regions in many instances were doing this also and the  
23 national review did not have as much information as the people  
24 that were doing it at the regional level. So the FAST Task  
25 force recommended that this be stopped at the national level.

1 And this process that Mr. Chambliss has been describing was  
2 to verify that indeed each of these Regional Medical Programs  
3 did have a process by which the projects were looked at from  
4 a technical point and other standpoints.

5 The national review then looks to see what the effect  
6 of all of these activities is, what the composite effect is,  
7 rather than the individual projects as such.

8 DR.JAMES: Then, I can relate very well how you may  
9 pick up in your visits the relationship of the CHP agencies in  
10 that respect.

11 Now, when you get down to the area of what happens  
12 as far as local applicants are concerned in the appeal mechanism,  
13 how are you able to sift that information out?

14 MRS. SILSBEE: The process by which the team looks  
15 at this is to look at the documentation that has occurred in  
16 the local review, to look to see what the records are, to see  
17 at what stage a project proposal gets stopped in the process,  
18 what the feedback is to the procedure, whether the Regional  
19 Advisory Group -- what kind of information they have about  
20 these ideas that they haven't been asked to act upon. These  
21 are all steps in this review process to make sure that someone  
22 who has an idea gets it considered and knows, if it hasn't  
23 been considered and approved locally, why.

24 DR. MARGULIES: For example, there is an effort made  
25 to interview unsuccessful applicants to see how they perceive

1 the process, how they got involved, what occurred when they  
2 were turned down, if they had an adequate explanation of why  
3 it was rejected, whether they feel the process was fair and so  
4 on. So that they try to get verification of the true dynamics  
5 of the review process.

6 DR. SCHMIDT: In previous discussions of this in the  
7 review committee, we have gone back to something that we are  
8 all very familiar with. And that is the project grant type of  
9 review conducted in NIH where, indeed, the technical review of  
10 a research grant is carried out by the study section on a  
11 one-by-one basis. But within NIH, there are developing  
12 centers. The so-called centers of excellence approach, for  
13 example, is one in which NIH will fund a center and then the  
14 center locally can fund research grants. And they must have  
15 the ability to do technical reviews then of the research  
16 projects within the center locally. And then the study  
17 section and the Council really serve to accredit the center to  
18 do this job.

19 So then you can translate that to Regional Medical  
20 Programs wherein the function of a review committee at times  
21 we have said is to accredit the region to do this job that as  
22 Judy pointed out used to be done by the review committee, in  
23 many cases not as well. And, finally, the people who we do  
24 it with come from regions anyway.

And when you play with this a little bit, you see

1 that in the kidney reviews, for example, recommendations have  
2 been made to get experts from without the region. And all of  
3 these sorts of things get into this. The triennial review  
4 and this sort of thing becomes an important aspect of this  
5 also there.

6 First Leonard and then --

7 DR. SCHERLIS: I think your analogy as far as  
8 centers of excellence is an analogy, but not, I think,  
9 paralleled by RMP type of organization because in each region,  
10 you do have an RMP. And in each region, you do set up a  
11 verification system. You aren't saying that is a center of  
12 excellence which really has all of the necessary technical  
13 skills to decide about each individual project.

14 If you select the center of excellence, it is in  
15 competition with many other centers. And you are selecting  
16 from a large pool in determining which ones do have over and  
17 above a system of review the basic ability, talent, and necessary  
18 review officers in that area who can look at it technically.

19 What I am getting to really is that I still believe  
20 that within this committee, we have a right to decide the  
21 quality of a program submitted by a sampling mechanism. And I  
22 find it invaluable in reaching a conclusion about an area to  
23 look at a project or two in order to determine whether they are  
24 just forwarding up to us some what otherwise would be very low  
25 priority items. And we have the decision and I think, indeed,

1 the responsibility to determine by such a sampling mechanism  
2 whether or not the overall grant request is a valid one.

3 I would like to interpret the results of whatever  
4 this discussion will be that you are not removing from our  
5 responsibility and purview the right and indeed the responsi-  
6 bility if we chose to look at individual projects as a sampling  
7 mechanism to determine our overall reaction to the entire  
8 request. Will you comment on that, please?

9 MRS. SILSBEE: That seems like a very reasonable  
10 approach. And in order to answer some of the questions that  
11 are asked in the review criteria, you would have to do this.  
12 But it does differ in that you don't go through each one and  
13 say this one is approved and this one is disapproved.

14 DR. SCHMIDT: I agree. What you have done really is  
15 described how we have been operating in the last year or two.  
16 And when you get right down to it, the program is a kind of  
17 a nebulous thing that is something more than the projects. But  
18 what you have in hand to look at really are the projects. And  
19 as we all know, even now regions are not making some decisions  
20 they should, but booting them up here. And, of course, what  
21 this means is that there is something wrong with that process  
22 and we have to continue to work with the region.

23 Dr. Florin.

24 DR. FLORIN: I might report on a recent visit. We  
25 thought our review process was quite adequate. It was pointed

1 out in the Regional Advisory Group meeting some of our short-  
2 comings. And it was accepted with understanding and with  
3 appreciation. And we have since modified some of our  
4 review mechanism to do it.

5 I think the major concern they had at our site  
6 review visit was that those applicants be informed of their  
7 right to appeal to the Regional Advisory Group at any time  
8 even though decisions have been made at a lower level before  
9 that time.

10 I think also to comment on another statement that was  
11 made by Dr. Scherlis, as funds become more competitive, the  
12 problem within the Regional Advisory Group was one of fairly  
13 good review in that they tried to cull through the projects  
14 so they didn't have poor projects. Hopefully, if the staff  
15 allowed them to come up that far, they would be eventually  
16 filtered out by the Regional Advisory Group. This isn't  
17 always possible, but I don't think the undue influence of  
18 people that early existed in that program is now evident cer-  
19 tainly in our areas.

20 DR. SCHMIDT: There was a comment along this side of  
21 the table.

22 MISS ANDERSON: I think I was going to comment on the  
23 fact that the site review teams have an opportunity to see  
24 some of the proposals in depth and bring it to this review  
25 committee for discussion.

1 DR. SCHMIDT: The comment for those who may not have  
2 heard it was the site review teams certainly can and do look  
3 at projects and use this as an entry point into the survey of  
4 the local decision-making process.

5 One question I would have is what are the plans for  
6 some kind of -- well, let's say, are the forthcoming site  
7 visits then as part of the triennial review the mechanism for  
8 looking at compliance or does staff intend to go back in a  
9 year or what mechanism of seeing to this process have you  
10 considered?

11 MR. CHAMBLISS: This will probably be done in a variety  
12 of ways. The staff is making regular visits, technical  
13 assistance visits, to the regions. And they will be monitoring  
14 and checking through with the provisions of these the  
15 verification as they go to see how they are being maintained  
16 and what the status of the region is as it relates to this  
17 decentralizing process.

18 DR. SCHMIDT: Yes, Mr. Toomey.

19 MR. TOOMEY: One of the things that bothers me is  
20 the number of times that one of the Regional Medical Programs --

21 DR. SCHMIDT: I am sorry, let me interrupt and ask  
22 you to talk into a microphone because there are people in  
23 the back row.

24 MR. TOOMEY: One of the things that bothers me is  
25 the number of times that a region is visited and the number of

1 purposes for which it is visited and the number of reviews that  
2 a region has. I know the last time that I visited as a site  
3 visitor, I think that within the period of four months, there  
4 had been a management assessment report, there had been a field  
5 trip, a technical review. And it just seemed that there was  
6 almost an unconscionable amount of visiting to that particular  
7 region, although I am sure each trip was justified. And we did  
8 get a report on it.

9 But the thing that bothers me is the fact that when  
10 we take the rating sheet, the review sheet that you spoke of,  
11 Judy, it really doesn't reflect the number of visits, the kind  
12 of visits, the results of the visits. It doesn't give the site  
13 review team real specific knowledge about what was found, what  
14 wasn't found.

15 I am not saying it right because really this discussion  
16 has brought on something that bothered me. And I am kind of  
17 struggling for the words a little bit. But in any event, it  
18 seems that there should be a more specific kind of indication.

19 I know what I was going to say. We do get the problems  
20 Now, this is for sure. We get them at the RAG level, the  
21 program development level, the field level, the staff level.  
22 We get the problems. And then you use another sheet to provide  
23 a rating mechanism for what has gone on. And sometimes the two  
24 don't jibe actually.

1 I look at the problems. And then as the review mechanism of  
2 what has gone on, you don't focus on the problems, you focus  
3 on process, performance, program, and some other things.

4 And this whole thing, the number of visits, the  
5 kind of visits, the purpose of the visits, the results of the  
6 visits and then the result of the site visit, don't seem to  
7 meld adequately.

8 DR. SCHMIDT: Let me ask for clarification.

9 MR. TOOMEY: I would ask, really, if anybody else  
10 has had this same kind of problem in bringing all this  
11 material together.

12 DR. SCHMIDT: Let me ask for clarification of one  
13 thing you said that I didn't understand. I recently made a  
14 site visit to a region that had been visited a number of times.  
15 And each group that went in pointed up the same deficiencies  
16 and the same problems. And we did, indeed, I thought, concen-  
17 trate on their problems.

18 What did you mean when you said that you go in and  
19 really don't concentrate on the problems? I missed your  
20 point.

21 MR. TOOMEY: I think the point is that you do concen-  
22 trate on the problems, but the problems that you find as a  
23 result of one are the problems as a result of three visits.  
24 And you actually have made a number of visits for a number of  
25 different purposes presumably, and they all come out the same

1 way.

2 And then my last point was that the assessment, the  
3 in-depth assessment, that starts with process and performance,  
4 these questions do not always relate to the problems that have  
5 been identified by previous visits except by indirection.

6 DR. MARGULIES: I think that is a valid problem, but  
7 I think that it has little to do with a sort of an accident in  
8 timing, Mr. Toomey, although staff may want to add to this.  
9 We have had an excessive concentration of necessity on two kinds  
10 of visits -- management assessment and the review process  
11 verification. These were necessary because we had undergone  
12 a profound change in the way in which we ran our affairs. This  
13 has meant in some cases a deluge of visits which include not  
14 only the regular visits, but the specialized ones for management  
15 assessment which we had to have and for review verification  
16 process as well.

17 I think in the future, there will be less of this  
18 kind of specialized attention to programs and a better  
19 opportunity to integrate them. I am suggesting that this is  
20 an erratic phenomenon rather than a consistent one which moved  
21 us from where we were to where we need to be.

22 Mr. Chambliss commented a moment ago on what we would  
23 be doing in the future. What we would like to believe is that  
24 this intensive period which we could not possibly duplicate  
25 as we could not duplicate management assessment visits sets a

1 plateau from which we can operate with attention to what comes  
2 up as a variant from the norm, but which we will then have to  
3 re-examine at some point to see if anything more intensive  
4 has to be done.

5 In fact, the responsibility for the two kinds of  
6 processes rested in different parts of the Operations Division.  
7 And we had our own difficulties in bringing them together because  
8 they did put a great strain on RMPs and added an amount of  
9 information which was not necessarily a part of the regular  
10 review process, but was rather a buttress for it.

11 DR. SCHMIDT: Of course, the review criteria and  
12 that kind of a laundry list and form for site visitors and  
13 so on was clearly intended to be a guide and not all-inclusive.  
14 And I know that many site visit teams have gone far beyond  
15 that guide. That was not intended in any way to restrict site  
16 visitors or the review committee or anything else. Of that,  
17 I am sure.

18 Judy.

19 MRS. SILSBEE: I was just going to say to Mr.  
20 Toomey in terms of trying to plot out these visits where they  
21 could be combined, the verification visit and management survey  
22 were put together. And the strategy within staff was to try to  
23 do that enough in advance if there were going to be a triennial  
24 site visit so that the region would have the benefit of the  
25 observations and recommendations and an opportunity to try to

1 correct some of these things before their three-year funding  
2 request got considered by the national review process. This  
3 didn't always work out.

4 DR. SCHMIDT: O.K., any other comments, then, on  
5 this subject?

6 MR. HILTON: I just need to follow Mr. Toomey's  
7 comment for just a little clarification for me.

8 From what Judy was saying, as I understand it, these  
9 visits, management, technical review, etc., etc., are they  
10 deliberately then timed to precede a visit by the review  
11 committee, Council, that kind of mixture, so that we in effect  
12 follow up to assure that what has been discovered in the  
13 earlier visits has begun to show returns? Leave the verifica-  
14 tion for staff?

15 MRS. SILSBEE: The thought behind that, Mr. Hilton,  
16 was that in some instances, this would relieve the site visitors  
17 of having to go over that same old ground and be able to  
18 concentrate more on the program and the activities and the  
19 effectiveness of those activities so that they wouldn't have to  
20 focus on the organizational structure so much.

21 MR. HILTON: Is that to say, then, as this develops  
22 there would be no need for us as we did, for example, to ask  
23 them to go through projects, that we are sure that the processes  
24 is legal and that kind of thing, we won't have to be bothered  
25 with that?

1 MRS. SILSBEE: I don't think that is indicated I  
2 think at any point in terms of the perspective of the applica-  
3 tion that these things have to be checked out as Dr.  
4 Scherlis was saying.

5 DR. SCHMIDT: I would get alarmed if anybody thought  
6 in any way they shouldn't do anything that their brain and  
7 tummy told them ought to be done on a site visit. And you know,  
8 you smell something, you go right in and find out what smells.

9 I think the thing that bothers me about this is as  
10 will come out in our discussion of regions in the later part  
11 of the meeting, why is it that there can indeed be a series  
12 of visits all pointing up the same thing? And what is wrong  
13 that over a period of even two consecutive triennial -- do we  
14 have any two consecutive -- the same things are there? And  
15 there is a certain obstinacy sometimes that one needs to  
16 change.

17 Well, fine. Bill.

18 DR. THURMAN: In no attempt to match the wit and  
19 eloquence of our chairman, let me point out Mr. Nixon's  
20 statement was the carrot-and-stick procedure was designed for  
21 the jackass.

22 (Laughter.)

23 DR. SCHMIDT: I think we have to take a recess to  
24 figure that one out.

1 that came from Congress. In talking about this congressional  
2 budget bureau and so on, one Congressman said that the Congress  
3 is fiscally irresponsible and if you added up the monies that  
4 Congress appropriates and spent that the country would obviously  
5 be broke. And one Congressman described Congress as a fiscal  
6 junkie which I thought was a great line.

7 I will use this for transition into the next subject.  
8 Those of you who read what I think, Dr. Margulies, was a very  
9 interesting and informative summary of the Council meeting --  
10 I hope that Review Committee members read the Council highlights -  
11 you will recall there was reference to the developmental  
12 component including a little bit peculiar fact noted by the  
13 Review Committee often. And that is the developmental component  
14 was often most needed by the region that didn't merit it. And  
15 for this and other reasons, the developmental component has been  
16 under serious discussion by the Council.

17 And Judy will review this for us and get us up to  
18 date on the status of the developmental component.

19 MRS. SILSBEE: Well, we were talking a little earlier  
20 about the fact that this review committee used to be involved  
21 with project review and the developmental component was  
22 introduced as a tool to help regions about the same time that  
23 we were trying to get regions in the habit of submitting an  
24 application for funding once a year rather than every time a  
review cycle came up. And the developmental component was at

1 that point, which wasn't too long ago when you really get back  
2 and look back and see what actually happened -- it was in  
3 1970 -- a revolutionary idea that the regions would request  
4 funds for projects and at the same time would request funds  
5 for activities that they didn't specify at the time except in  
6 terms of the areas in which they would want to develop programs.  
7 And at the time this committee and Council considered the  
8 developmental component, they decided that there had to be  
9 certain standards for those regions which were to be approved  
10 for the developmental component.

11 And in practice, this became a way of sifting out those  
12 regions which had Regional Advisory Groups which were able to  
13 make decisions, withstand the local pressures of some kind of  
14 technical review. There were a number of different qualifica-  
15 tions.

16 And in terms of the way this review committee  
17 recommended the regions receiving developmental components,  
18 looking back over the past two years, it sifted out pretty  
19 well. If we look at the regions that are roughly in the A  
20 category and the B category and C category, in the A, most all  
21 -- and one region had not requested a developmental component --  
22 of those were approved for developmental component. In the B  
23 area, I think of 26 -- and when you do these categories, it  
24 depends on what point in time you are doing it -- 20 of them  
25 have been approved. In the C area, only one or two. So in

1 terms of a way of sifting out regions, it has been effective.

2 But since the developmental component was introduced  
3 and has been utilized, the regions themselves, the ones that  
4 have decided to allocate their funds in this direction because  
5 we have never actually given additional money for that purpose,  
6 we have had a number of other things happen. We have decen-  
7 tralized the project review. The RMP review processes have  
8 been studied. This triennial system has been inaugurated.  
9 We have the RAG grantee policy which states very clearly what  
10 the Regional Advisory Groups' role is in a more succinct  
11 fashion than ever before. And we have the policy for discre-  
12 tionary funding which provides the opportunity for a region  
13 to do everything that the developmental component allowed them  
14 to do if they are approved for triennial status. And then regions  
15 have the opportunity to shift funds to initiate activities  
16 within one application time to another.

17 And at this point in time, it seems that the  
18 developmental component as such, a request for it as such, has  
19 served its purpose, and it is no longer a necessary part of  
20 this evolution into decentralization.

21 In looking at the results, there are a number of  
22 regions that have requested developmental components two or  
23 three times and been disapproved each time. So as a mechanism  
24 for getting them to do the things that Mr. Toomey says he keeps  
25 seeing coming up in every report, it didn't seem to be effective.

1 And at the same time, there seemed to be for those regions  
2 that needed to initiate some new ideas or move in different  
3 directions, they were using their disapproval for developmental  
4 component as -- they interpreted that action as disapproval of  
5 the type of activities they were going into rather than some  
6 difficulty with their decision-making and local review.

7           So at this point in time, staff feels that the  
8 developmental component has been a very useful device. It has  
9 served its purpose. Regions have had ample opportunity to  
10 request it and that it might be better to eliminate that as a  
11 special thing -- not eliminate the developmental idea, but  
12 to eliminated the component as such which has created some  
13 problems internally.

14           DR. SCHMIDT: I think that is an excellent review.  
15 And, of course, the existence of discretionary funds really is  
16 to me what renders the developmental component a little bit  
17 unnecessary now because the developmental component was  
18 intended to provide, indeed, discretionary funds. It got to  
19 be sort of like the stamp on meat, unfortunately.

20           I forget what the current grading is now. But if  
21 you got the developmental component, you were stamped choice  
22 or whatever the top grade is which is sort of ridiculous.

23           MR. CHAMBLISS: Prime.

24           DR. MARGULIES: You have forgotten about it because  
25 it cost so much.

1 DR. SCHMIDT: I am on the verge of forgetting  
2 about meat because it costs so much.

3 Dr. Scherlis, you had a furrowed brow at several points.

4 DR. SCHERLIS: That is a lack of good vision rather  
5 than any reaction to your comments.

6 (Laughter.)

7 DR. SCHMIDT: Then put on your glasses because we  
8 need your clarity of vision on this committee very much.

9 Joe.

10 DR. HESS: Just a question for further clarification.

11 As I have understood the use of the developmental component,  
12 this has been some funds that they could use in a variety of  
13 ways. How will that be requested now in the future in  
14 applications?

15 MRS. SILSBEE: At the present time and through March,  
16 it will be requested just as it has been. But if there are  
17 some revised instructions, it would provide an opportunity to  
18 put that in the program staff budget as developmental activities  
19 which is where they have been putting some of these funds anyway.  
20 In looking at the situation right now, regions sometimes are  
21 requesting a developmental component, then under their program  
22 staff budget, they are requesting money for feasibility studies,  
23 they are requesting money for contracts and a number of things  
24 which have the same purpose. So we thought if we could get  
25 it, it would be tighter if we could get it all in one place.

1 DR. SCHMIDT: What will be interesting is when we  
2 arrive at the point this afternoon or tomorrow morning when a  
3 region has had a review verification visit and has had this  
4 project approved and the recommendations of the site visit  
5 team will be in that region that they do not merit a develop-  
6 mental component. And we will see how that comes out. I will  
7 predict we will have that situation.

8 Mr. Hilton.

9 MR. HILTON: Such terms as aside from developmental  
10 component, growth funds, rebudgeting or budgetary flexibility,  
11 discretionary funds, I am assuming there is no substantial  
12 difference between those terms; they all are really saying the  
13 same thing. I am surprised, however, to note that I have  
14 seen at least one application in which more than one term is  
15 used for one application. And so they are kind of doubling  
16 up on flexibility.

17 How many different ways do you provide incentive  
18 and how much of that do you tolerate? I guess I am seeking  
19 guidance.

20 MRS. SILSBEE: Mr. Hilton, this has been a concern  
21 and is part of the reason why staff looked at this whole area  
22 of developmental component.

23 In terms of the discretionary funding policy which  
24 came out about the same time as the RAG grantees policy, it  
25 again puts a burden both on our staff and this review committee

1 of looking at the results of a lot of flexibility after they  
2 have already initiated it rather than before. And in looking  
3 at the ways in which regions have used developmental funds, there  
4 have been very exciting things that have occurred. And there  
5 have also been some of the other kinds where they have put it  
6 all together and started a project.

7 So we have to monitor this very carefully. But if  
8 we could put it all in one spot, we think it will be more helpful.

9 MR. HILTON: So you are saying if we get an applica-  
10 tion like that and they are asking for four different kinds of  
11 flexible money, we could easily disallow three out of four or  
12 something if that seemed to be feasible.

13 MRS. SILSBEE: If it seemed like an undue proportion  
14 without any kind of justification. And this is certainly  
15 within the line --

16 MR. HILTON: This whole question of degrees of  
17 extra money like everything else.

18 DR. SCHMIDT: All right, let me seek out now any  
19 comments from anyone around the table, anyone who is here  
20 as representative of the public. Are there any general comments  
21 or questions not necessarily directed at the last topic from  
22 anyone in the room?

23 (No response.)

24 If there are none, then I think that we will declare  
25 that this section of the Review Committee meeting is closed.

1 We will reconvene at 1 o'clock in then the first of the closed  
2 sections that will be devoted to program review.

3 Leonard.

4 DR. SCHERLIS: I have no comment except an inquiry.  
5 Have you determined who would or would not be here tomorrow in  
6 terms of making sure that the review can be done today?  
7 Has this been taken care of?

8 DR. SCHMIDT: The information I have -- we can do  
9 this little bit of housekeeping right now -- is that Dr. White  
10 will be here this afternoon only; that we must do today  
11 Alaska, Connecticut, and North Dakota in part because of your  
12 schedule.

13 Is there anyone else who is involved in a conflict?

14 MR. HILTON: Yes, Mr. Chairman. Unfortunately, I,  
15 too, will only be able to be here this afternoon.

16 DR. SCHMIDT: All right, we have got Washington/  
17 Alaska scheduled also. So I intend to work the committee very  
18 hard this afternoon and do the most we can today with this so  
19 that we have the benefit of the members who may not be here  
20 tomorrow. So eat heartily and have a good strong cup of coffee  
21 and come back with loins girded.

22 (Whereupon, at 11:55 o'clock a.m., the meeting  
23 recessed, to reconvene at 1 p.m. the same day.)

24

AFTERNOON SESSION

(1:00 p.m.)

DR. SCHMIDT: I think I will call the meeting to order.

Let me first suggest an order, kind of doubling back to the last topic. And it would seem to me that -- let's see, Phil isn't here yet and will be coming about 1:30, I think. And giving him a little while to get here, it might be 2 o'clock. So I would suggest the following order: Washington/Alaska first, and then Louisiana, then Connecticut and North Dakota, then Metro D.C.

Now, those seem to me to be the musts this afternoon. And if we go on beyond that, it would be good.

Is that acceptable? Have I left out some imperative?

(No response.)

If not, then let's start with Washington/Alaska. The primary reviewer is Mr. Hilton and then Dr. Luginbuhl is the secondary reviewer.

Oh, yes, I forgot to bring to the attention of the review committee the conflict of interest statement and the confidentiality of meeting statement. You know that we cannot participate in situations in which we may have a conflict of interest. Committee members will absent themselves when regions in which they have an interest are discussed.

I don't have to read this, do I?

1 MRS. SILSBEE: No, since everyone has it in front of  
2 them.

3 DR. SCHMIDT: You all have a copy. This is a require-  
4 ment of meetings.

5 Then, before we do start with Washington/Alaska,  
6 Mr. Chambliss will inform us as to the Council recommendation  
7 stemming from our last review meeting.

8 MR. CHAMBLISS: As a result of the September-October  
9 review cycle at which time 13 regions were reviewed by this  
10 committee, 9 of which had applications in for the triennium,  
11 3 anniversaries prior to the triennium, and one anniversary  
12 within the triennium, we certainly thought the committee would  
13 like to know that all of the committee recommendations were  
14 accepted by the Council with the exception of one. And that  
15 was the case of New Mexico.

16 In the New Mexico application, there was a site  
17 visit recommendation of a funding level of \$1.3 million. The  
18 committee recommended \$1,150,000. And Council upped that  
19 level and recommended a level of \$1,250,000 which was \$100,000  
20 above that recommended by this committee.

21 DR. SCHERLIS: Was there a reason given?

22 MR. CHAMBLISS: And I simply thought you would want  
23 to know of those proceedings.

24 Thank you.

25 DR. SCHMIDT: Let's take Leonard's question. What

1 was the reasoning behind this?

2 MR. CHAMBLISS: The question is the reasoning. And  
3 would you speak to that, Mr. Posta?

4 MR. POSTA: I might pass the ball over.

5 However, actually, Dr. Kamaroff was on the site visit  
6 to New Mexico and did differ with the committee's report and  
7 actually brought in a number of the improved activities which  
8 had taken place in New Mexico in a complete reorganization and  
9 felt perhaps they did deserve a little bit more what we used  
10 to call until this morning 'developmental component funds. And  
11 that was the primary reason for it to be increased in a slight  
12 amount.

13 Is there any other comment?

14 MR. ZIZLAVSKY: An additional comment, Dr. Kamaroff  
15 who chaired the site visit felt it was a little bit stringent  
16 and they should have a little bit more in funds and not in  
17 flexibility. The actual amount of funds awarded, however, was  
18 more in line with the committee's recommendation.

19 MISS KERR: I notice on the summary sheet requests,  
20 it is footnoted No. 3, Review Committee rating gave Connecticut  
21 312 which would place it in the B category. And it was changed  
22 by Council to be an A region.

23 I wonder if you could give us the reason for that  
24 or why this was changed?

25 MR. CHAMBLISS: Let's see, Mr. Nash who is the Chief

1 of the Eastern Operations Branch -- Miss Kerr raises the question  
2 on the rating for Connecticut.

3 MISS KERR: The rating changes for Connecticut from  
4 B to A.

5 MR. NASH: That was raised by Council itself.

6 MRS. FAATZ: That was a year ago.

7 MR. NASH: It wasn't here.

8 MRS. FAATZ: We are reviewing Connecticut again.

9 MR. NASH: It was a site visit, by the way.

10 MISS KERR: Well, I notice it was on this sheet.

11 DR. SCHMIDT: We will be doing Connecticut so maybe  
12 we can hold that off, then.

13 Are there any other questions specifically directed  
14 toward the Council actions?

15 (No response.)

16 If not, then I think that does bring us to the  
17 program reviews. And for those of you who have just come in,  
18 the order will be Washington/Alaska, Louisiana, Connecticut,  
19 North Dakota, and Metro D.C., beginning with Washington/Alaska  
20 and Mr. Hilton.

21 (Dr. Ancrum absented herself from the room.)

22 MR. HILTON: Ted Moore from the staff will provide  
23 a few minutes of introductory information using the audio-visual  
24 and then we will go into our report.

25 DR. SCHMIDT: We will have audio-visual presentations

1 on Washington/Alaska, Louisiana, and Intermountain which we  
2 hope will be helpful. And once again, we will want your  
3 critical evaluation of these presentations.

4 MR. MOORE: We don't have a speaker, but of the  
5 3.5 million people in the two States.

6 (Slide.)

7 As you can see, this is Washington State. And the  
8 3.2 million people in the population areas of Bellingham, Seattle  
9 to Tacoma, 80 percent of the population resides in this area  
10 here surrounded by the Olympic Mountain Ranges and the  
11 Cascade Mountain Ranges. The rest of the State is flatland.  
12 And the other 20 percent of the population is in Spokane and  
13 Walla Walla and a few other small places in this area.

14 One large river, the Columbia River, stretches 1500  
15 miles into Oregon and.

16 Next slide.

17 (Slide.)

... 18 Alaska has 310,000 population. Population bases are  
19 located here -- capital at Juneau, Anchorage the largest city,  
20 Fairbanks in the central part with a scattering population on  
21 the coastal regions.

22 You have the Brooks Mountain Ranges in the north and  
23 the Alaskan Ranges in the south with Mt. McKinley's 20,000  
24 foot peak here.

25 Next slide.

1 (Slide.)

2 The region encompasses 700,000 square miles. As you  
3 can see, it is approximately one-fifth the land area of the  
4 United States.

5 Along with the size, the terrain density of population,  
6 weather and so forth, you can see where this would add problems  
7 to health care planning and health care services.

8 Next slide.

9 (Slide.)

10 These are air mile distances between the larger  
11 cities in the area of Seattle, Portland, Spokane, Fairbanks,  
12 and Anchorage. As you can see, it is quite a problem to travel  
13 to RAG meetings and other committee meetings. Three days are  
14 allowed for such meetings.

15 It is very hard to consider that the time that we  
16 leave National Airport in Washington, people are leaving  
17 Fairbanks to attend the same meeting in Seattle.

18 With the isolation that contributes to the goals of  
19 accessibility and availability of care, however, the people  
20 were able to see the Super Bowl via satellite communications.

21 Next slide.

22 (Slide.)

23 This is a view of Bethel, Alaska. It is Main Street  
24 Bethel, 1500 population, in southwest Alaska.

25 Next slide.

1 (Slide.)

2 This gives a population percentage breakdown within  
3 Washington and Alaska. In Alaska, of the 310,000 people there,  
4 you have around 9,000 blacks, you have 52,000 Indian-Eskimos,  
5 2,000 other, and the remaining is 79 percent Caucasian.

6 In Washington, you have 3.5 million population.  
7 71,000 blacks, 53,000 of Oriental extraction, Indian population  
8 33,000, remainder Caucasian, or 95 percent.

9 In Alaska, there is around a 40 percent shortage of  
10 primary care physicians. They have a total of 320 physicians,  
11 half of whom are military or PHS physicians.

12 In Washington they have a little above the national  
13 average of health manpower in terms of physicians and nurses.

14 Next slide.

15 (Slide.)

16 These are the areawide planning agencies. There are  
17 7 in the State of Washington. There is one in Alaska in  
18 Anchorage.

19 As you can see, the shaded portions are covered.  
20 The unshaded portions are not covered by any Federal or State  
21 planning health agency.

22 Next slide.

23 (Slide.)

24 This is a composition of the various committees,  
25 Washington/Alaska committees. Some are technical and others

1 are on the broader committee functions. As you can see,  
2 around the populated areas, you have representation in kidney,  
3 continuing education, Community Health Service, heart,  
4 cancer, and health care technology. So representation flows  
5 with the population bases centered around the university.

6 Next slide.

7 (Slide.)

8 As a result of some of the earlier planning -- this  
9 is the total RAB membership. There are 46 members in the State  
10 of Washington. This gives a geographical distribution of the  
11 membership. Advice given by the management assessment team in  
12 February of 70 indicated that they needed a larger geographical  
13 spread, professional spread, consumer and other groups on the  
14 RAB. And this shows the geographical spread.

15 Also, of the 46, 8 members are from Alaska. And  
16 there are around 9 consumers on the total Regional Advisory  
17 Board.

18 Next slide.

19 (Slide.)

20 This is the Alaskan Advisory Committee composed of  
21 22 members. They assess the health needs in Alaska. And this  
22 is a communication device into the RAB. Eight of these 22  
23 members are also RAB members.

24 Next slide.

25 (Slide.)

1 As a result of some of the earlier planning -- this  
2 is the Providence Hospital in Anchorage, Alaska -- prior to  
3 1969, there was no super radiation therapy available to the  
4 Alaskans. Many cancer patients had to travel 3,000 miles to  
5 other States for their radiation therapy. RMP purchased the  
6 cobalt unit and the community provided the financing and built  
7 the facility you see here.

8 In its first year of operation, 135 patients completed  
9 therapy at the unit which was twice as much as had been expected.  
10 Today, 300 to 400 patients receive cobalt treatment at this  
11 center.

12 This is one of the first successful RMP projects  
13 which, of course, have been taken over with other resources.

14 Let's have the transparency.

15 Mr. Hilton, would you like to present the planning  
16 process for their triennial application?

17 MR. HILTON: I think probably, Ted, we can hold off  
18 on that planning process slide unless questions arise.

19 Is that the one you are about to show? We will hold  
20 up on that one.

21 Here is an additional audio-visual aid, and I also  
22 have a handout to share with you.

23 Basically, our approach to the Washington/Alaska  
24 region was what might be qualified as a --

25 DR. SCHMIDT: Could you kind of cozy up to that mike

1 a little bit?

2 MR. HILTON: O.K.

3 Our basic approach to the Washington/Alaska region  
4 was what might be described as somewhat negative in that we  
5 sought initially to identify what the problems were, what was  
6 wrong in the region, understanding from the literature that it  
7 apparently has a rather good history, that it is really very  
8 highly rated by staff. Still, there were problem areas. And  
9 really, I guess we can probably break them into two types --  
10 what might be called minor league problems, problems, for  
11 example, revealed in the management verification visit, such  
12 things as not providing adequate feedback to applicants. And  
13 there was a question at one time about the number of vacancies  
14 on staff and the lack of an evaluation director and a number of  
15 other problems.

16 There were also major concerns, some of which were  
17 not entirely resolved as of our site visit. And we have some  
18 recommendation as to that these perhaps ought to be watched.

19 Among the major concerns as I have characterized  
20 them, there were really five. One question ~~that~~ arose was with  
21 regard to the future of the coordinator or director, Donal  
22 Sparkman, of the Alaska Regional Medical Program who has been  
23 apparently a very strong leader in the region since it became  
24 active. He is approaching retirement age. He has indicated to  
25 us that it is an option that he is not going to pick up and that

1 he will be able to continue to provide leadership.

2 Part of that whole package in terms of leadership,  
3 of course, depends on the appointment of a rather strong  
4 deputy director. And we have received assurances that this,  
5 too, would be done and that such a person is presently being  
6 sought.

7 There was a legal concern raised, legal in terms of  
8 RMPS policies and procedures, with regard to the memorandum of  
9 understandings which the RAB staff have been drawn up with the  
10 grantee organization, University of Washington Medical School,  
11 in that the memorandum of understanding includes a statement  
12 which in effect says that the RAB can override the grantee  
13 should the grantee decide to fire the coordinator.

14 And staff called that to the attention of the RAB, an  
15 it is one of the things that should be called attention to in  
16 the advice letter. And staff should look again at that at some  
17 point in the not too distant future to see that it has been  
18 corrected.

19 There were reports about a possible degree of competi-  
20 tion between two health education type activities in the  
21 Washington/Alaska region. One of them, one that was established  
22 first, called the WAMI program -- that's W-A-M-I which  
23 stands for Washington/Alaska/Montana and Idaho -- is a coopera-  
24 tive program in which medical students can come to the  
25 University of Washington for part of their clinical training and

1 then go back home, and the whole idea being to sort of centralize  
2 this kind of activity on the medical student.

3           When the local RMP came up with another HSEA program  
4 a little later on and sought cooperation of the grantee, there  
5 was some difficulty there. There remains some uneasiness on this  
6 point, although we were confident after talking with Dean van  
7 Citters of the Medical School and the staff -- we had, I think,  
8 some very helpful open and frank discussions with him on these  
9 problems -- that it wasn't a problem that couldn't be resolved.  
10 There have apparently been very good relationships between  
11 the grantee and the RMP.

12           This seems to have been the only problem that can be  
13 really regarded as a significant problem that has evolved in  
14 the 6-year relationship between the two bodies. And it is not  
15 one that we necessarily see as jeopardizing the relationship  
16 at this point in time. But again that is something staff  
17 ought to be aware of and be mindful of.

18           There was a concern about the degree of planning  
19 input that was being received from the CHP agencies. And  
20 considerable discussion centered on this point. Representation  
21 from the Region 10 office was on hand.

22           Apparently the blame for the problem rests in both  
23 parties, both the RMP and CHP. The CHP has not been responding,  
24 making appropriate meaningful kinds of comments on materials as  
25 they come to them for review. And the RMP has not felt it

1 necessary, apparently, to give the CHP sufficient leadership  
2 or respect on their commentary at all. And there has been  
3 this kind of emotional friction between the two.

4           Again, our feeling was that an advice letter to the  
5 RMP or an item in the advice letter to the RMP, on this matter  
6 would help to resolve the problem.

7           It was also my feeling that some similar step  
8 should be taken on the other side of the confrontation to get  
9 CHP's cooperation a little better. And staff assures us this  
10 will happen to Region 10 staff. It is going to be resolved  
11 that way.

12           Another kind of major problem we got involved with  
13 the Washington/Alaska program centers was on the lack of any  
14 real comprehensible system of arranging operational requests,  
15 of establishing priorities.

16           Now, apparently prior to the visit, some serious  
17 thought had been given to this between the time of the  
18 application and our actual site visit. And some more thought  
19 had been given to this.

20           We did spend some time with staff in which period  
21 a system was described to us. And admittedly, it was a new  
22 system, somewhat complicated in some respects, but nevertheless  
23 a system. Whether or not it is workable, will be workable,  
24 is something to be proven in time. And again we are advised  
25 that this is something that staff might look at.

1           These were the major problems. The other problems  
2 I mentioned that evolved from the management review team,  
3 problems on feedback letters to applicants, problems on the  
4 structure of the review bodies, etc., were for the most part  
5 to the best we could determine -- and we sort of subcommitted  
6 ourselves to deal with these issues -- were resolved by the  
7 time of our meeting.

8           We ranked this particular region -- and I say we --  
9 the site visit team ranked this particular region. And most  
10 of the site visit members, by the way, had not had the  
11 opportunity to do this before and had not had any in-depth  
12 background information on the region. And even so, from our  
13 own independent observations and inquiries and conversations  
14 with staff and others who had been participating with the RMP,  
15 we ourselves came up with a pretty high rating. And in talking  
16 to some of the staff, I understand they rated themselves a  
17 little bit lower. But nevertheless, this has been a pretty  
18 good region as far as we could determine in our investigations.

19           They are requesting funding for a triennial period,  
20 06, 07, 08 years. Their requests are recorded on some of the  
21 materials here. This document has a good brief statement on  
22 it.

23                   For the 06 year, \$3,173,000.

24                   07, \$4,480,000.

25                   08, \$4,421,000.

1 Our recommendations are that for the first year,  
2 06 year, \$2,500,000. \$3,000,000 for each of the subsequent  
3 years. And we have not involved ourselves at all with the  
4 910 application centering on the Fred Hutchinson Cancer  
5 Center there and have accepted their requests as they stand.

6 I can best proceed from here on the basis of  
7 questions which you might want to hold until after Dr. Luginbuhl  
8 has made his comments.

9 By the way, the handout I gave you tends to break  
10 those figures down and make it more easily assimilatable.

11 Did everyone get one of these now?

12 DR. LUGINBUHL: I followed the instructions laid  
13 down by our chairman, and I went out trying to smell out the  
14 problems in this program. And in looking over the material in  
15 the meetings prior to meeting with the group out there, I made  
16 a list of areas that I thought we should dig into. And they  
17 included program management, planning process, program evaluation  
18 and the budget. I will comment briefly on each of these and  
19 try to be quite brief because I think you did cover them, too.

20 As far as program management is concerned, Dr.  
21 Sparkman is due to retire. And he was allowed to stay on one  
22 year on the basis of a waiver by the university. And the head  
23 of the RAG and Dr. Sparkman seems to feel that he would be  
24 allowed to stay on indefinitely on an annual review basis.

25 I did have the opportunity to discuss this with the

1 dean of the medical school, and he told me that it was with  
2 some difficulty he got this clearance. And I think this is an  
3 unresolved question therefore and probably should be addressed.

4       There was also question of the continuity of leader-  
5 ship in the RAG in that the chairman appears to be a very strong  
6 individual and very capable, is up for reappointment. And I  
7 think they have a limitation on reappointment. He, however,  
8 felt that there were other people that would provide continuity.  
9 And, indeed, there is a waiver provision so that he might be  
10 reappointed.

11       My impression was that it had been a very strong  
12 group and there were a number of individuals who were very  
13 important to that group. But there does appear to be the  
14 potential for continuity.

15       The planning process, as Bill said, we did pursue in  
16 some depth. And I think none of us were completely convinced  
17 that the planning process is as well coupled to the program  
18 goals and priorities as we would wish. I for one got the  
19 impression that they have set up goals and priorities, but when  
20 it comes to approving projects, they do this and then sort of  
21 relate them back to the priorities after the fact.

22       I feel that is an area that does require continued  
23 attention.

24       As far as evaluation is concerned, they have put a  
25 lot of effort into evaluation. I don't think they have solved

1 the problem by any manner of means, but I was impressed they  
2 were making some real progress in this area.

3 Do you want me to talk about budget now in more  
4 detail?

5 MR. HILTON: Yes.

6 DR. LUGINBUHL: The budget for the three-year period  
7 as submitted was a total \$12.1 million. And the first year  
8 was \$3.1 million, the second and third year were each  
9 approximately \$4.4 million. The budget in the current year is  
10 \$1.8 million.

11 I for one and I think other members felt it was  
12 virtually impossible to adequately analyze a budget of this  
13 magnitude in the time allotted. But we did the best we could.

14 We really felt that we would have to almost delve  
15 into some of the individual projects and review some staffing  
16 and staff assignments to tell whether that is a logical budget  
17 or not. And we just simply couldn't do that as you all can  
18 well imagine.

19 We reviewed the proposed new positions and reached  
20 the conclusion these might be well reduced, especially consider-  
21 ing the number of unfilled positions.

22 We also felt that funds could be cut from the  
23 proposed developmental aspects. This conclusion was reached  
24 in part by the realization that these developmental activities  
25 were designed to yield an increase in the second year of

1 \$1.3 million in new project activity. And this could almost  
2 certainly not be funded even if developed.

3 And we did review their ranking of projects. And  
4 some of them had a low priority. And we felt that they could  
5 well be reduced. And therefore, we made a cut in that area as  
6 well in our thinking.

7 Using this approach, the budget for the first year  
8 of the triennium of \$2.5 million was recommended and budgets  
9 of \$3 million for the second and third year were recommended,  
10 recognizing these latter years would be subject to additional  
11 review.

12 The increase of approximately \$700,000 between the  
13 current year and the coming year was thought to be a generous  
14 award and one that would tax the capacity of the program.

15 In summary, I thought it, from my limited experience,  
16 seemed to be a pretty good program and deserved encouragement.  
17 The strength had been because of the staff and the leadership  
18 of the board. There were deficiencies, and it was impossible  
19 to really deal with effectiveness of individual projects.

20 We did feel that they could handle additional funds,  
21 but certainly not the amount that they requested.

22 MR. HILTON: I guess we could hold staff comment and  
23 handle questions.

24 DR. SCHMIDT: Let's go ahead, then. Are you prepared  
25 to make a motion at this time to get something on the floor?

1 MR. HILTON: I would move then our recommendations of  
2 \$2.5, \$3 and \$3 million for those three consecutive years.

3 DR. SCHMIDT: \$2.5, \$3 and \$3. Now, this is exclusive  
4 of the 910 projects. That is not a part of it.

5 MR. HILTON: Actually, it includes the 910  
6 projects.

7 MR. MOORE: No, no. It includes the developmental  
8 component and kidney projects, but not the 910.

9 DR. SCHMIDT: It does include the developmental?

10 DR. LUGINBUHL: And the renal.

11 DR. SCHMIDT: And renal, but not the 910.

12 MR. HILTON: Not the 910.

13 DR. SCHMIDT: Then, you are seconding the motion?

14 DR. LUGINBUHL: Yes, sir.

15 DR. SCHMIDT: So that we do have a motion on the floor.

16 I will do three things very quickly. I want to remind  
17 the committee of your rating sheets, these big long things.

18 The other one is to welcome Phil White.

19 Welcome, Phil. It is nice to see your face in the  
20 room.

21 The other one is just for the fun of it. I spent  
22 part of last week with Dave Rogers, a good friend of RMP.

23 We had him out for visiting Professor of Medicine. Those of  
24 you who know what he is doing know why we had him out as

25 visiting Professor of Medicine.

1 (Laughter.)

2 And we spent a fun evening drinking and talking. And  
3 a good part of the conversation revolved around what I think  
4 has become a kind of a legendary site visit -- the first one  
5 in Washington/Alaska where Dave went and Martha Phillips went,  
6 and I was there. And this was a magnificent visit. I still  
7 start shaking when I think about it.

8 But he spent a great amount of time talking about  
9 Washington/Alaska, that visit and RMP.

10 The floor, then, is open for comments or questions.

11 Joe.

12 DR. HESS: I would without knowing a great deal of  
13 detail about the program, but accepting your evaluation as a  
14 quite good one, concur that the recommended increase of  
15 \$700,000 a year is a fairly generous one. And I am wondering  
16 about the further increment of another half-million dollars in  
17 the second and third years.

18 It seems to me that is a rather substantial escalation  
19 for a region who though it has problems probably is at least in  
20 the middle range as you look nationally of resources and  
21 geographic and other kinds of things which get in the way of  
22 delivering health services.

23 And I wonder if you might comment a little bit more  
24 on your rationale for that steep an escalation.

25 MR. HILTON: Well, Bill has done an excellent job,

1 I think, of recounting much of the thinking of the committee  
2 as we struggled with this item of budget in terms of some of  
3 the elements he mentioned -- reasonable projections as we saw  
4 them, really looking at what they wanted, really looking at  
5 their ranking systems, and in effect in terms of our, for  
6 example, projects budget, working with their recommendations  
7 and shaving that back somewhat.

8           You mentioned the cost element because of the resource  
9 I think it was very much impressed on many of us that this  
10 region does have some pretty excessive costs because of the  
11 broad expanse of land territory. And their emphases are upon  
12 not only accessibility which I guess would account for a greater  
13 -- in fact, which does account for the greatest portion of  
14 their budget, but they also have taken into account acceptability  
15 of health care which becomes very important in terms of the  
16 diverse kinds of populations they are trying to serve in Alaska  
17 and elsewhere.

18           And they do have some considerable extra costs. It  
19 takes them three days travel time to come to a RAB meeting, for  
20 example. They don't have as many RAB members from Alaska because  
21 of the transportation problem largely.

22           Those kinds of things in addition to as careful a  
23 study as we could make in time, although their projects and  
24 their staffing requirements really led to that kind of --

25           DR. HESS: My question is can you justify a half a

1 half a million dollars a year further escalation for those  
2 kinds of things?

3 DR. LUGINBUHL: Let me say at the outset I really  
4 don't feel that I could go through this budget either in the  
5 first of the three years or in either of the subsequent two  
6 years and justify it in the kind of detail that I wish I could  
7 give you. I simply don't think you can take a \$12 million  
8 program and in two days break down a budget in the kinds of  
9 detail that I would like.

10 I think that we concentrated on the first year. And  
11 we did make a very concerted effort in the time allotted to  
12 build that budget up by looking at the staffing pattern, by  
13 looking at the kinds of projects that they had ranked, and those  
14 that we thought could be eliminated, what they might reasonably  
15 be able to expand, and so on.

16 They were very ambitious about expanding that program,  
17 and they felt that they would put a great deal of effort into  
18 the development of new projects in the first year and then  
19 ask for money to carry them out in the subsequent two years.

20 I would say that our \$3 million figure, the half-million  
21 dollar increase, is going along at this stage with their hope  
22 they can expand their activities. I would regard it as a very  
23 tentative recommendation. It is one that I certainly wouldn't  
24 want to have firmly set at this point in time.

1 with the understanding it is going to be reviewed. And I think  
2 when it is reviewed, particular attention has to be given to  
3 what kinds of new projects they develop that they then want to  
4 fund in the second and third years. I certainly don't feel  
5 that that should be a firm figure at this point in time.

6 DR. HESS: We ought to do something about it because  
7 that recommendation is a firm recommendation.

8 DR. SCHMIDT: John.

9 DR. KRALEWSKI: I am concerned over that budget also.  
10 And I was wondering if you might provide us with a couple  
11 other pieces of information that might help to evaluate it.

12 One, I would be interested in whether or not they  
13 have some unexpanded funds for this year that might be carried  
14 over.

15 Two, the question over their core staff, the vacancies  
16 they now have. Will they be able to fill those and will they  
17 be able in your estimation to then add the people that they  
18 are hoping to add to expand it to this budget?

19 And then, number three, their record of phasing out  
20 projects. Are we funding here projects over a long period of  
21 time or are they phasing out the projects or are these new  
22 ones? And are there a large amount of new ones and are they  
23 all solid projects?

24 MR. MOORE: Yes. In answer to the first question, we  
25 were told they would be zero balance. They would not be

1 carryover funds.

2 DR. KRALEWSKI: How can there be with all the  
3 vacancies they have?

4 DR. THURMAN: They rebudgeted. That is what Judy was  
5 talking about all morning.

6 DR. SCHERLIS: They knew you were going to ask that  
7 question.

8 MR. RUSSELL: Historically, this program has managed  
9 their finances extremely well and have because of discretionary  
10 funds the flexibility RMPs have who have very consciously and  
11 carefully budgeted their unexpended funds which because of  
12 their good management processes, they have been able to look  
13 down the road and see what was going to lapse when and where and  
14 plow that money back into the programs.

15 MR. HILTON: On the question of phasing out, they do  
16 have a pretty good history of gathering continuing support.  
17 We had one question about one project, No. 5, which apparently  
18 has been or will be by a set date in fact effectively phased  
19 out. We had some question as to some of the resources that  
20 might show up in another project further down the road.

21 But they have been pretty successful in getting  
22 continued support for projects.

23 You also asked a question about core staff. And as  
24 I recall our deliberations on that, I can only say that I  
25 would imagine the site visit team was confident in the ability

1 of the leadership there to fill the position. We didn't give  
2 them as many positions as they wanted. We were reasonably  
3 confident they could fill the ones we allowed them to have.

4 MR. RUSSELL: There are a number of candidates under  
5 consideration now for the deputy position. They have been  
6 actively recruiting.

7 DR. SCHMIDT: John.

8 DR. KRALEWSKI: Can I follow that with one question?

9 Under your plan here, then, how many positions would  
10 they have to fill this coming year?

11 MR. MOORE: We were told that within two months they  
12 would have the deputy director, the director of professional  
13 education, and the director of medical services. So there  
14 would be three positions, top positions, filled within two  
15 months.

16 DR. KRALEWSKI: How many additional positions would  
17 be in this budget?

18 MR. MOORE: The additional positions below directors  
19 grade, I believe, are around 15. And most of those are in  
20 community health services, spread out in Spokane and Alaska,  
21 to be above those subregional offices.

22 DR. SCHMIDT: Bill.

23 DR. THURMAN: Could you give us just a little bit of  
24 a rundown on the relationship of the Fred Hutchinson Cancer  
25 Center? I think the only reason I ask it, and I think it is

1 pertinent, is that over a quarter of a million dollars and  
2 going up each year of this budget is for relationship to it.  
3 And probably more than that if we really knew.

4 MR. MOORE: The direct relationship to it is the  
5 910 application which is \$66,000 which would provide the  
6 Regional Cancer Council --

7 MR. HILTON: Are you asking about the background of  
8 the center?

9 DR. THURMAN: No, how this relates to it. Because  
10 I think if you look at several things down here requested for  
11 06, 07, and 08 and add them up, they are half a million dollars  
12 which basically is going to go into the Fred Hutchinson. Do  
13 we understand how that is going to work or is that just down the  
14 pike?

15 DR. LUGINBUHL: Dick.

... 16 MR. RUSSELL: The 910 figure shown there represents  
17 the support of the Regional Cancer Council which will cover  
18 more than just the State of Washington. We advised the  
19 Washington/Alaska RMP that we did not think it would be  
20 appropriate for the Washington/Alaska RMP to support totally  
21 the Fred Hutchinson Cancer Research Center, that Regional  
22 Council.

23 Does this help any?

24 DR. THURMAN: It helps some, Dick, but there are  
25 other things like Project 52 that really basically are going

1 to be Fred Hutchinson Cancer care. And they are worth a quarter  
2 of a million dollars right there. Yet we don't have a building  
3 yet, do we?

4 MR. RUSSELL: No, not yet. The status of the  
5 building is that we funded the one phase of it which is worth  
6 \$5 million. NCI has just recently approved, and their award  
7 is expected soon for the rest of the building.

8 So, no, it is not up yet by any means.

9 DR. LUGINBUHL: Could I ask a question?

10 DR. SCHMIDT: Are you asking what the relationship  
11 is of the RMP program funded projects in cancer?

12 DR. THURMAN: Related to the Fred Hutchinson.

13 DR. SCHMIDT: To that upcoming center. In other  
14 words, is a good part of the dollars going to the Washington/  
15 Alaska Regional Medical Program going in point of fact to be  
16 spent in that center?

17 DR. THURMAN: Right. And that is why I think it is  
18 pertinent. Because going back to Joe's initial question, they  
19 are asking, and we are projecting, a very large slug of money.  
20 And yet we really don't have any bricks and mortar on which to  
21 spend the money. That is a little bit nebulous.

22 DR. SCHMIDT: Those are new projects that you were  
23 adding up?

24 DR. THURMAN: Yes.

25 DR. LUGINBUHL: I don't think it is correct to say

1 we are projecting funds specifically for the Fred Hutchinson  
2 Cancer Center in that we simply gave an overall recommendation.  
3 And I would point out that we did cut \$1.4 million out of the  
4 second year and the same amount approximately out of the third  
5 year. That was obviously not a categorical cut; it is a  
6 general cut.

7 I would like to ask a procedural question and that  
8 is if we approve tentatively a \$3 million figure, what is the  
9 further review that will occur?

10 DR. SCHMIDT: I was going to make this point in a  
11 minute in regard to what Joe is saying. The dollar figure that  
12 we put on is in effect a ceiling. And unless Council would  
13 override our recommendation, the \$3 million for the subsequent  
14 two years becomes a ceiling which they could not exceed.

15 DR. LUGINBUHL: It is a ceiling or a floor?

16 DR. SCHMIDT: It is a ceiling and not a floor. There  
17 is really no floor. The floor is set by the availability of  
18 funds which is the first one.

19 And then, secondly, when this comes up, there will be  
20 a staff anniversary review of the application. And staff will  
21 make a recommendation. And we have later on some recommenda-  
22 tions coming before the committee.

23 And staff, of course, is guided by the instructions  
24 given from the site visits and review committee and is guided  
25 by the concerns expressed by the committee during this discussion

1 DR. HESS: Just as a matter of further emphasis, I  
2 don't think we ought to take that ceiling too lightly. Because  
3 what it says in effect is that if there is enough money to go  
4 around and do everything that they could be funded up to that  
5 level. And I think the question that we have to -- or one  
6 question that we have to -- be concerned with here as we are  
7 trying to look at the country nationally is not just do they  
8 have a good program and would these things be worthwhile doing,  
9 but in relationship to all other programs countrywide can we  
10 justify spending this much money for this program?

11 The site visit team goes in with a narrow view, and  
12 we should take the broad view when it comes here to this table.  
13 And it is from that base that I have some serious reservations.

14 DR. SCHMIDT: There is a real trap here, though, and  
15 that is that the committee must act consistently. And I will  
16 listen very carefully for the committee's actions over a two-  
17 day period because if the committee looks at one region and has  
18 that in mind and then tomorrow morning after a night's sleep  
19 and so on makes judgments without the total number of dollars  
20 available for the country in mind, then really there is an  
21 inconsistency in the committee actions.

22 And the business of reviewing and making judgments by  
23 merit kind of irrespective of availability of dollars is  
24 something that Dr. Margulies talked about a little bit this  
25 morning.

1           The decision as to the allocation of what funds  
2 are available, of course, is made at a level superior even to  
3 the Council. And there is some balancing here between regions,  
4 depending on availability of funds.

5           DR. HESS: I don't disagree with what you are saying.  
6 In most respects, Mac, we don't know. We won't know tomorrow  
7 what the availability of funds is. But I think there is a  
8 kind of a general feeling or balancing that we need to try to  
9 do here in terms of looking at both the quality of the RMP staff  
10 and the elements that go into the program, the needs of the  
11 region, the relative resources which they have, and so on.

12           And as a general practice in order to be consistent,  
13 I think we ought to be trying on a national basis to channel  
14 the most help to the regions which have the greatest number of  
15 problems. And it is that kind of balancing and consistency  
16 which I am arguing for. And I certainly agree that we ought  
17 to be consistent, but I think consistent with the broad  
18 picture in mind, what the overall goal is.

19           DR. SCHMIDT: Well, let's see -- Leonard.

20           DR. SCHERLIS: I was interested in one particular  
21 project -- the patient care appraisal and continuing education  
22 one. Because over a three-year period, that absorbs well over  
23 \$1 million. And although I don't like to review small projects,  
24 I think in view of our discussion earlier today about peer  
25 review and quality control, I would be very interested in this.

1 It is sponsored, I think, by the medical society.

2 I was wondering what sort of a program it is. It  
3 is a million dollars, and I think it is worth spending a little  
4 time on.

5 MR. HILTON: I think we broke ourselves down into  
6 committees, and it seems to me we had some discussion on that  
7 patient care appraisal. And I am not certain now, Bill, in my  
8 memory, who handled that.

9 DR. SCHMIDT: Ceci.

10 MISS CONRATH: This is the implementation on the  
11 statewide basis on a program that has been going on for about  
12 three years. This is the plain ground approach, the tri-cycle  
13 approach of physicians within an institution determining what  
14 criteria they are going to use for quality of care, looking at  
15 records and determining deficits, implementing an educational  
16 program and evaluating results.

17 The State medical societies became very much interested  
18 in it and has undertaken this as their major activity.

19 About two years ago, they passed a resolution for  
20 assessing a portion of the annual dues -- namely, \$10 per  
21 member per year -- to help underwrite the expenses of a  
22 continuing education program that has as its goal improvement  
23 of patient care. And this is their major program thrust.

24 This is probably the most extensive program in the  
25 country in terms of implementing on a statewide basis this

?  
1    plan ground approach in community hospitals throughout the  
2    State.

3           Alaska is also interested in this and plans next year  
4    to implement it. They have a core of faculty; they have  
5    probably one of the most thorough community organization schemes  
6    in the country to really test out the principles of this  
7    approach.

8           DR. SCHMIDT: Leonard, do you want to push that a  
9    little more?

10          DR. SCHERLIS: Only if any other information is  
11    available. Perhaps you could comment in the view of our  
12    discussion earlier today how this fits in with H.R. 1.

13          DR. SCHMIDT: Let's see, do they have plans to extend  
14    that or relate that to what must come along in peer review or  
15    PSROs?

16          MISS CONRATH: This is the first cut of peer review.  
17    It is a peer review approach. And it probably means that  
18    Washington would be able to move, depending on how PSRO  
19    evolves. They will have a cadre of people who are more  
20    sophisticated in terms of peer review and also in terms of  
21    criteria setting than is true in other places.

22          DR. THURMAN: Ceci, do they have an EMCRO in addition  
23    to that?

24          MISS CONRATH: I don't know. I don't think they do.  
25    This is the culmination of about three years of work

1 with the State Medical Society, the School of Medicine, and  
2 RMP. There is a film on it that has been used, I guess, in  
3 about 25 States -- on the patient care appraisal. We saw  
4 portions of it.

5 MISS ANDERSON: Does it include the other health  
6 professionals, Ceci?

7 MISS CONRATH: They are beginning to in the last  
8 six months through Larry Hulbert and the group. Both nursing  
9 and allied health are involved and some other projects --  
10 namely, the laboratory projects -- have long-range plans to  
11 interface with the projects. At the moment, it is physician  
12 oriented, but the continuing education program in nursing is  
13 patterning its approach on this particular program.

14 DR. SCHMIDT: Mrs. Flood: . . . . .

15 MRS. FLOOD: I have a question to ask in regard to  
16 that particular project, too, with respect to the \$3 million  
17 within a three-year period. Have they developed a mechanism  
18 for the continuation of the program without RMP support?

19 MISS CONRATH: Namely through the Washington State  
20 Medical Association through the membership dues. How this is  
21 going to work out, I don't know, but it has already got about  
22 \$35,000 a year going in through membership dues about the last  
23 year and a half. How it goes in from this point on, I don't  
24 know.

1 MRS. FLOOD: Up to \$375,000.

2 DR. ELLIS: That is just about one-tenth of what they  
3 need to operate in the year.

4 MISS CONRATH: This is the beginning.

5 DR. SCHMIDT: Joe.

6 DR. HESS: I have a process type question. And that  
7 is how did they through their goals and priorities arrive at  
8 a project of this type funded at this level?

9 MR. HILTON: We took them through the process on a  
10 couple of projects, not this particular one.

11 Would it be of help maybe if we went through the  
12 process as they do it generally?

13 DR. HESS: No. I was just curious. This is a very  
14 expensive project for this kind of thing. I am not arguing.

15 I believe it is a very excellent type of thing to be doing.

16 I am just questioning the amount of money that is going into  
17 it. And I am wondering if this in relation to all their other  
18 problems and needs is the most effective way to use that much  
19 money.

20 I am trying to use this as an example of their  
21 decision-making process to see how they arrived at a recommenda-  
22 tion of that nature because to me it seems a little out of  
23 balance with what I would expect. And I just wonder if they  
24 had good justification for it.

25 DR. LUGINBUHL: As I said, we really did not try to

1 review individual projects. We did go spend quite a long time  
2 with them on their ranking, their mechanism of ranking. And  
3 once again, as I said earlier, I for one was not convinced that  
4 they had a sound coupling of their projects in all cases to  
5 their priorities and goals.

6 What we did with the projects, as I recall, is look  
7 over the list. And our feeling was that there were a number  
8 of projects that were either of lower priority or were very  
9 large in the amount of funding requested. And rather than  
10 try to make recommendations on them individually, we made an  
11 overall cut. And the overall cut was about \$1.5 million per  
12 year in the second and third year.

13 But once again, I really don't feel that I could  
14 build up a budget for \$3 million any more logically than I  
15 could build one up for \$3.1 or \$2.9 million. I am sorry, but  
16 I honestly don't think I have the kind of confidence in this  
17 figure that I would like or that you would like.

18 And I don't know how you can do it given the nature  
19 of the review process.

20 MR. HILTON: I am a little confused at this point on  
21 one thing. And, again, in the area of process, we talk about an  
22 overall, and it was indeed as Bill says, an overall cut. It is  
23 true that we did look at some particulars, but generally it was  
24 a figure that we shaved out. And we think we built in enough  
25 flexibility for the leadership of the program, looking at

1 program primarily, to handle.

2 With regard to any single project that appears on the  
3 printouts, there is no specific guideline. We could have had  
4 we the time gone down project by project and shown what was  
5 cut out or what percentage was cut out. But as long as there  
6 was an overall cut and as a percentage of one million plus  
7 dollars are extracted, I don't know what the decision of the  
8 leadership would be in the face of that. They don't know yet  
9 what we are talking about.

10 But we can't really say that this project, in other  
11 words, is going to cost that much. We didn't say specifically  
12 and have not made it known to you or to them that we are saying  
13 only 50 percent of their patient appraisal. Maybe they will  
14 elect that the million or so we cut out is the patient  
15 appraisal.

16 DR. SCHMIDT: Leonard.

17 DR. SCHERLIS: One or two questions.

18 In your feedback session or during your actual review  
19 site visit, did you have occasion to ask their leadership if  
20 they had set up a priority rating so if they got \$1 million  
21 instead of \$10 million or whatever the sum might be, that  
22 they were able to delete certain projects?

23 MR. HILTON: Yes.

24 DR. SCHERLIS: Did you have presented to you that  
25 priority?

1 MR. HILTON: In fact, we raised that several times  
2 because if you look at the application, it is somewhat confusing  
3 there. Their explanation which involved a system of attaching  
4 if I recall correctly numbers, weights and values --

5 MR. MOORE: A, B, C, high, low.

6 MR. HILTON: A, B, C, high, low. They have a system  
7 which they explained to us, and we asked for a sample of what  
8 would happen. And I do recall in this particular area, there  
9 was some concern especially on the part of Dr. Ogden that we  
10 were suggesting what the budget might be. And we tried to  
11 point out we simply wanted to see them go through a dry run of  
12 the project.

13 DR. SCHERLIS: Can I ask one more specific question  
14 about a project? And that is Emergency Medical Services which  
15 looks like a good system except it seems to be sponsored by the  
16 Tacoma Community College. And it isn't just training. It  
17 talks about setting up a total system, grading emergency rooms  
18 and so on.

19 And I was just curious, having had experience looking  
20 at various sponsors of EMS, this was unique, having a community  
21 college being sponsor.

22 Do you have any details on that?

23 MR. HILTON: What project number is it?

24 DR. SCHERLIS: 64, 064.

25 DR. SCHMIDT: Miss Conrath?

1 DR. SCHERLIS: I don't want to belabor the point. I  
2 just asked as a question of curiosity.

3 MISS CONRATH: I don't have particulars on that.  
4 But the plan in Washington is different than in many other  
5 places -- namely, the community college is a recipient for  
6 many community programs which are not training in which  
7 the community college system in the State of Washington under-  
8 takes wide, broad-scale community activities way beyond the  
9 usual. And in this case, I think this is probably what is  
10 happening. They serve as the sponsoring agency.

11 It is a much stronger community force than is true  
12 in many other parts of the country.

13 DR. LUGINBUHL: I think the most serious question  
14 about this program is a question about continuity of leadership.  
15 And if indeed Dr. Sparkman does retire because of university  
16 regulations and if indeed they do not get a replacement or even  
17 now a qualified deputy for him and if there is a significant  
18 turnover in the leadership of the RAG, then I would be very  
19 concerned about the level of funding. I frankly feel that  
20 the level recommended would be too high.

21 If these problems are not solved as we were told they  
22 would be solved -- we identified the problems, we discussed  
23 them, we were given assurances that they were being addressed --  
24 if in fact they are not addressed and these basic problems are  
25 not solved, then I would feel very strongly that the funding

1 should be scaled down in keeping with their capacity. Because  
2 I don't feel that without continuity of leadership, they would  
3 have the capacity to expend this amount of money.

4 But once again, I visualized it as a ceiling, but  
5 certainly not as a floor.

6 DR. SCHMIDT: Joe.

7 DR. HESS: Primarily with concern for consistency  
8 with what we have done at past meetings and what we are  
9 probably going to do in the future based on past experience,  
10 I would like to offer a substitute motion for funding for this  
11 region, something which I think is more in line with what we  
12 have done in the past with regions of similar capability and  
13 similar needs as best we understand them under these limited  
14 circumstances. And that is for the first year, the funding be  
15 \$2.3, for the second \$2.4, and for the third \$2.5.

16 That gives them a half-million dollars increment  
17 over their current level of funding which I think is a fairly  
18 generous one and a pretty good vote of confidence in the  
19 program and also gives them a gradual increment of dollars  
20 \$100,000 a year over the next three years to provide for some  
21 expansion. Within those funds, they still have the flexibility  
22 for reallocating monies as they see fit.

23 So I would just like to offer that as a substitute.

24 DR. SCHMIDT: The dean here has a great ploy. He  
25 just whipped out a slide rule.

1 I installed a computer terminal in my office. And  
2 whenever I really don't know what to say, I whirl around and  
3 start punching my computer terminal. And usually when I whirl  
4 back, the person I am talking to has turned absolutely white.

5 DR. LUGINBUHL: We can't afford that.

6 DR. SCHMIDT: The computer terminal isn't hooked up  
7 to anything, it is just a computer terminal.

8 (Laughter.)

9 We have a motion on the floor, then, which I will  
10 accept as a substitute motion. Is there a second?

11 MISS ANDERSON: I will second it.

12 DR. SCHMIDT: All right, there is a second so we are  
13 now discussing a substitute motion of \$2.3, \$2.4, and \$2.5.  
14 And I do two things in this case.

15 Assuming that the site visit team has looked at this  
16 very carefully as have staff, I ask specifically if anyone  
17 feels that there might be some breakage or some damage done to  
18 let the committee know about this sort of thing if they feel  
19 that this would do harm.

20 Mr. Dean, what does your slip stick say?

21 DR. LUGINBUHL: I don't think that the \$2.3 recommenda  
22 tion for the first year would produce serious damage. I would  
23 be a little more concerned about the increase of \$100,000 in  
24 the next two years. That is about a 4 percent increase, there-  
25 abouts. And I think that the escalation of costs would be

1 probably greater than that.

2           Their increase in the first year is based in part on  
3 a rather ambitious planning of new projects. And I think that  
4 if we gave them \$2.3 and they then planned the projects and  
5 had \$2.4 the following year, they wouldn't be able to carry  
6 many of them out.

7           I would be happier to see at least the potential for  
8 a greater increase in the second and third years, although I  
9 think the actual award should be based on an assessment on  
10 how they have done during that first year and whether they have  
11 indeed solved these potential management problems.

12           DR. SCHMIDT: Again, as we said, there would indeed  
13 be an assessment. And if these if's that you talked about did  
14 come to pass, then the staff review would surface these concerns.

15           All right, let me ask the staff if any staff has  
16 comments on the substitute motion?

17           MR. RUSSELL: I have been sitting here trying to  
18 separate emotional reaction and applying it to reality. I  
19 would just like to point out that this is a program that has  
20 had, I think, probably one of the strongest Regional Advisory  
21 Boards in the country.

22           The board has been deeply involved. They do make the  
23 decisions. Through the review process management survey,  
24 we have found out they do have very good management review  
25 processes.

1           They have responded to criticism in the past and have  
2 in the last, I believe it is, year, Ted, they have really  
3 expanded their community service organization.

4           MR. MOORE: Subregionalization.

5           MR. RUSSELL: And I guess I am saying I would like  
6 to see them get a little bigger vote of confidence. But I do  
7 think the concerns about this next year are valid, are real.

8           But going along with Dr. Luginbuhl, I would like to  
9 make a plea for greater movement in subsequent years if their  
10 plans do materialize.

11          DR. SCHMIDT: Bill.

12          MR. HILTON: I was just going to say, Mr. Chairman,  
13 I am following your suggestion and am not thinking about next  
14 year. And I am assuming that is what we are supposed to do in  
15 our review of all of these programs and to concern ourselves  
16 with the information before us which I think is more consistent  
17 with what has been the case in the past before next year looms  
18 so close to us.

19          DR. SCHMIDT: If what you are saying is we should  
20 not base decisions on a supposition of what might happen two  
21 or three years from now, I would agree.

22          MR. HILTON: Exactly.

23          DR. SCHMIDT: However, with the triennial review, we  
24 must make a recommendation for the three years of funding.

25          MR. MOORE: There are about six activities which --

1 DR. SCHMIDT: Use the mike, would you, please?

2 MR. MOORE: There are about six activities which they  
3 are planning for 1974 which are not included in the first year's  
4 request. And these, of course, are patient care appraisal  
5 in Alaska, rural health care programs, hypertensive programs,  
6 Emergency Medical Services. So these and also health service  
7 education activities, they are moving very slowly as you heard  
8 earlier in the health service education activities. But with  
9 the first year's planning through various studies, they had  
10 planned to do some of these things for the second and third  
11 year of the triennial. And these are the things that really  
12 took up the half-million dollars in the \$2.5 and \$3.0.

13 So they are moving ahead in these areas for the  
14 second and third year.

15 DR. SCHMIDT: I think we are drawing to the time  
16 where we must begin testing sentiment of the group. If someone  
17 has some new point directed toward the substitute motion, they  
18 may have the floor. If no one demands the floor, I will call  
19 the question on the substitute motion.

20 MR. TOOMEY: I would agree with the dean. I think  
21 if we are --

22 DR. SCHMIDT: Would you use the mike, please?

23 MR. TOOMEY: I would like to suggest to Dr. Hess  
24 perhaps he might change his funding from \$100,000 perhaps to  
25 increase the two additional years to \$200,000.

1 DR. HESS: I would say at 5.5 percent increase annual  
2 something like that, that might end up \$150,000, something of  
3 that nature.

4 MR. TOOMEY: I think that would be more reasonable.

5 DR. SCHMIDT: A 5.5 percent annual increment is what  
6 is usually calculated as the amount necessary to meet infla-  
7 tionary costs. This would not give them new program dollars  
8 probably.

9 MISS KERR: That is what concerns me in view of his  
10 statement in what they are planning in the years ahead that  
11 it is hardly enough room to move.

12 MISS ANDERSON: Wouldn't they be discontinuing some  
13 proposals?

14 MR. TOOMEY: May I suggest the 5.5 percent is on  
15 wages? And if you take the whole ball of wax as the Wage  
16 and Price Control Board has looked at it, you are closer to  
17 7 to 8 as far as they are concerned, although I don't want to  
18 argue about the 5.5, 1.6, or --

19 DR. SCHMIDT: Well, we have got \$2.3, \$2.4, and \$2.5.  
20 I won't accept another substitute motion. I would accept an  
21 amendment to the substitute motion.

22 If not, then I will call the question.

23 MR. TOOMEY: I would recommend it be amended to be  
24 \$2.3, \$2.5, \$2.7.

25 DR. LUGINBUHL: I will second it.

1 DR. SCHMIDT: All right, I will accept that as an  
2 amendment to the substitute motion which is proper parliamentary-  
3 wise.

4 Any comments on that, then?

5 (No response.)

6 I think it is time to test sentiment, then. We are  
7 voting on \$2.3, \$2.5, and \$2.7.

8 All in favor please say, "Aye."

9 (Chorus of ayes.)

10 Opposed, "No."

11 DR. KRALEWSKI: No.

12 MR. HILTON: No.

13 DR. SCHMIDT: To my ear, the eyes clearly have it.

14 I am running the motion through. I think we are done.

15 DR. KRALEWSKI: No, that was the amendment.

16 DR. SCHMIDT: Oh, that was the amendment, that's  
17 correct. So now we are to the substitute motion. That's right.  
18 Thank you. Which is \$2.3, \$2.5, and \$2.7.

19 All in favor of that, please raise your hand.

20 We are voting now on the substitute motion of  
21 \$2.3, \$2.5, and \$2.7.

22 DR. SCHERLIS: You have thoroughly confused me.

23 You control your faculties obviously by not letting  
24 them know what they are voting on.

25 DR. SCHMIDT: No, I write the minutes. That is where

1 I control them.

2 (Laughter.)

3 The original motion was \$2.5, \$3, and \$3. We then  
4 had a substitute motion which was \$2.3, \$2.4, and \$2.5. We  
5 then successfully amended the substitute motion to be \$2.3,  
6 \$2.5, and \$2.7.

7 We will now vote. And if we adopt the substitute  
8 motion, the funding levels then will be \$2.3, \$2.5, and \$2.7.

9 Is that clear?

10 DR. SCHERLIS: Yes, sir.

11 DR. SCHMIDT: Is it correct?

12 (Laughter.)

13 DR. THURMAN: Dr. Scherlis is suggesting you ought to  
14 hook up the computer.

15 DR. SCHMIDT: The chair declares that out of order  
16 and what I said to be correct.

17 Does anyone wish the floor before the vote?

18 (No response.)

19 If not, all in favor then of the substitute motion  
20 as amended please raise your hand.

21 (Hands were raised.)

22 It is nine ayes.

23 Opposed, no, raise your hand.

24 (Four hands were raised.)

25 Nine to four vote. The motion carries.

1 Thank you very much.

2 The question is do we need a special action on the  
3 910? Who can answer that?

4 MR. RUSSELL: It is being considered as a separate  
5 application. Yes.

6 DR. SCHMIDT: All right, then, we have a separate  
7 thing to act on which is the application for funds under  
8 Section 910.

9 DR. THERMAN: Move their approval.

10 MISS KERR: Second the motion.

11 DR. SCHMIDT: There is a motion to approve that is  
12 seconded. Is there wish to discuss?

13 (No response.)

14 If not, all in favor, please say, "Aye."

15 (Chorus of ayes.)

16 Opposed, "No."

17 The ayes have it. You have your recommendation.

18 We will ask Phil to come up and join his old team-  
19 mates at the table. And we will move on to Louisiana.

20 DR. SCHERLIS: Mr. Chairman, I would submit if you  
21 were to have a poll for that last vote that you just had, and I  
22 would urge you to ask that --

23 DR. SCHMIDT: I have a growing suspicion you are out  
24 of order, but go ahead.

25 DR. SCHERLIS: No, I question very much whether or

1 not the people who voted knew what they were voting on  
2 with that last bit. Would you please ask whether or not that  
3 is indeed so.

4 I, for one, abstained because I didn't know what the  
5 vote was about. Could you clarify what the 910 was?

6 Am I alone in that?

7 (Indications he was not alone.)

8 DR. SCHMIDT: If Mr. Hilton agrees with you, we are  
9 in bad trouble.

10 Would the primary reviewer please address the  
11 question?

12 MR. HILTON: No. I heard other questions like that.

13 DR. SCHMIDT: Well, I gave you all at least two  
14 seconds to comment.

15 MR. TOOMEY: Take a moment, will you?

16 DR. SCHMIDT: I will accept a motion from the floor  
17 to reconsider that if anyone wishes to make such a motion.

18 DR. SCHERLIS: I would ask for a point of information  
19 first to explain what it was, that last vote. I am not being  
20 facetious. There is some question here as far as what it includ  
21 This is the intent.

22 DR. THURMAN: Can I speak to that, Mr. Chairman,  
23 since I made the motion?

24 DR. SCHMIDT: Please do.

25 DR. THURMAN: I think the move for approval of the

1 910 application basically relates to somewhere between \$66  
2 and \$89 thousand that is floating around in reference to  
3 organization structure and continuing communication for  
4 development of the cancer center concept. It does not relate  
5 specifically to construction funds or operational funds at  
6 the present time. And that was the genesis of my motion and  
7 the gist of it as well.

8 DR. SCHMIDT: Thank you.

9 Judy.

10 MRS. SILSBEE: No, he stated it very well. There are  
11 two separate applications in from this area, one having to do  
12 with the Regional Medical Program and the other a 910 having  
13 to do with this Fred Hutchinson Cancer Center that is now  
14 being constructed.

15 And in order to clear our books, we needed an action  
16 on that request which is for the first year \$66,402, the second  
17 year \$72,130, and a third year \$75,346.

18 Our reason for asking for that is again shorthand.  
19 The site visit team didn't make a specific recommendation for  
20 funding with regard to this application, although they looked  
21 at it and talked about it. And we needed this action in order  
22 to clear our books.

23 DR. SCHERLIS: And this is not in violation of the  
24 Council's statement which said in addition except as outlined  
25 in discretionary funding policy, no special approvals are

1 required by an RMP program to carry out activities authorized  
2 by Section 910? This is not in violation of that?

3 MRS. SILSBEE: No.

4 MR. HILTON: Judy, I have a question. My figure for  
5 the first year, the 06 year, for the 910 was higher I got out  
6 of some of the documents here. I have a \$86,000 figure. You  
7 said \$66,000?

8 MRS. SILSBEE: You are probably talking about total  
9 costs. I am talking about direct cost.

10 MR. HILTON: Oh, I see.

11 MRS. FLOOD: No, there was one copy with \$86,000, but  
12 that has been corrected.

13 MR. RUSSELL: Ted, wasn't that budget reduced after  
14 submission of the application?

15 MRS. SILSBEE: Where is Mr. Moore?

16 MR. MOORE: Yes, it was reduced half-time salary for  
17 Dr. Spielholz. So there should be an amendment in here with  
18 the \$66,000.

19 DR. SCHMIDT: The figure is \$66,402.

20 Does that give you the information required?

21 Really, my reading of this was this was something  
22 in a way we were at least politically committed to.

23 All right, we will move ahead then to Louisiana, Dr.  
24 Brindley.

25 DR. BRINDLEY: Louisiana, the region encompasses the

1 entire State of Louisiana, a population of 3.6 million. They  
2 have three medical schools. The average income is considerably  
3 less than the national average.

4       It has been an interesting complex to study. They  
5 made the original application in June of 1966. It was denied.  
6 They had planning funds in December of 1966. They asked for  
7 operational funds in 1968. That was denied. The second  
8 operation application was approved in August of 1969.

9       In November of 1971, we had a site visit. Dr. White  
10 was chairman of the site visit and will discuss that some a  
11 little bit later.

12       They related that they were impressed with the sound  
13 data base and that the planning framework was excellent but  
14 there were some deficiencies that we would like to show on the  
15 screen a little bit later.

16       The RMP is requesting \$1,040,233 direct cost. This  
17 figure is \$40,233 above the Council approved level for the fourth  
18 year. And although they were approved last year for \$1 million,  
19 they actually received \$738,818 for program staff and for  
20 projects.

21       However, in addition to that, they also were awarded  
22 \$705,969 in earmarked funds for three EMS projects and four of  
23 the HSEA and a pediatric pulmonary project.

24       Now, the application for the triennial status was  
25 denied last year. They are not applying for triennial status

1 this year. They have indicated that they probably will apply  
2 for triennial status next year.

3 They did have a certification visit to the Louisiana  
4 Regional Medical Program. I have a letter of January 12  
5 about that. The visit was made on December 14. I will give  
6 you a 12-word summary.

7 They thought everything was in good shape, and they  
8 recommended that it be approved. We can look at the details  
9 of that if you wish to.

10 A management survey visit was performed on November 7  
11 through 10 of 1972. And a number of their items, we would like  
12 to discuss as we project some of these on the screen. But in  
13 essence, management seems to be good.

14 There does seem to be some room for improvement as  
15 far as program direction is concerned and perhaps in planning.  
16 But the management seemed to be good according to the survey.

17 Now, if we might show some of these, please.

18 (Slide.)

19 I have had a question about who the grantee was, and I  
20 will just mention that that in March of 1970, a nonprofit  
21 corporation of LRMP, Incorporated, replaced the Louisiana  
22 State Department of Hospitals as the grantee. There were some  
23 problems related to that. The corporation was governed by a  
24 9-member board of trustees. They were not RAG members. And  
25 according to their bylaws, they seemed to pretty much have the

1 authority of deciding who would be on RAG and what the monies  
2 would be used for.

3 Our first map up here shows the CHP B agencies that  
4 can see here. And we have four funded agencies -- New Orleans,  
5 Baton Rouge, Monroe, and Alexandria -- and three operational,  
6 but unfunded -- Lafayette, Shreveport, and Lake Charles.

7 Now, we will try another one.

8 (Slide.)

9 This shows the projects that have been terminated.  
10 And largely the conclusion is that it shows that the projects  
11 have been moved away from concentrating largely on New Orleans.  
12 Actually, nearly all of the projects were in the New Orleans  
13 area.

14 Next.

15 (Slide.)

16 Here are the ongoing projects that you can see.

17 What is more, now we are becoming much more regional in dis-  
18 tribution.

19 We have only one statewide project, but 7 subregional  
20 projects have been added.

21 Now, can we show the chart?

22 (Slide.)

23 This emphasizes the new projects. It does show the  
24 regionalization much better than we have had before.

25 Next chart.

1 (Slide.)

2 Now, Dr. White will probably discuss again in a few  
3 minutes some of the recommendations of their site review  
4 committee. But to relate to some of these as we go along, the  
5 first one, improved RAG involvement, Dr. White's group found  
6 that the RAG was not very much involved, that the grantee  
7 organization at that time was largely calling the shots and  
8 deciding who was going to actually be involved and mostly how  
9 their program might develop.

10 After this recommendation and after staff had been  
11 there and related these suggestions to them, three fundamental  
12 committees of RAG had been appointed -- program development,  
13 evaluation, budget and finance. There are a number of other  
14 subcommittees that have been developed also, but these major  
15 committees have been appointed. And RAG has become much more  
16 involved in the direction of the program.

17 The site committee did recommend revision of the RAG-  
18 grantee relationship. As I mentioned a while ago, this was not  
19 very tenable. The grantee group and especially the executive  
20 committee was largely controlling the membership on the RAG and  
21 the direction of the program.

22 Now, the grantee bylaws have been altered, and they  
23 have removed this restriction. And the RAG has become much  
24 more autonomous.

25 As a matter of fact, the evaluation groups that have

1 been there have said that now RAG does seem to be the group  
2 that is determining the direction of the program.

3 And in our management survey that went there, they  
4 felt this was even so good that it might be considered as a  
5 model, demonstrating the relationships between the three groups.

6 Dr. White's group suggested we should have increased  
7 minority representation. And it was not very good at the time  
8 that this group reviewed them. They have improved this.  
9 There now are five members of the minority on RAG and one on  
10 staff. And they have increased the assistance to the agencies  
11 serving the minorities.

12 There is still room for further improvement. We do  
13 not have enough either on staff or on RAG, but they are moving  
14 in the right direction and do show a recognition of the importance  
15 of this and of the intent.

16 They have recommended that they clarify the RMP/CHP  
17 implementing and planning agencies. Initially, there were not  
18 many funds in CHP and RAG took over the important planning  
19 group in developing the data. And they did establish a very  
20 firm data base and a planning program.

21 It seems important now that that largely be reversed  
22 and CHP would go more into planning as indicated and implementa-  
23 tion be done by RMP.

24 RMP has indicated that it wished to take on this  
25 function and CHP actually has agreed to it and is cooperating

1 with them. They actually are the sponsors now of some of the  
2 projects.

3 Next.

4 (Slide.)

5 One of the criticisms was that it become more  
6 action oriented in their program. They had more planners than  
7 they actually did people who were developing on program. And  
8 that they needed to stimulate funds from other than RMP sources.

9 In improvement, we have noted that the staff now has  
10 four project developers and three planners. They have secured  
11 \$131,000 of outside support, and they have assisted other  
12 agencies in gaining another \$612,000 in Federal support which  
13 is a rather remarkable achievement.

14 It was indicated they need to refine their goals  
15 and objectives. The goals they had first were large. They  
16 did not have many subgoals. There were very few means of  
17 evaluation, time of achievement, how much was being accomplished.

18 They have five pages of goals in here which I can  
19 read to you, but they now are relevant and understandable.  
20 They do have systems of recognizing priorities. There is a  
21 good criticism there that there is no time frame.

22 And I think one also might recognize the deficit  
23 that there is not a good method of evaluation of program.

24 There are projects, but not too much of evaluating  
25 progress or program. However, it seems like nearly all RMPs

1 we review have that deficit, too.

2 Criticism was made they needed to develop more  
3 relevant action plans. And in response to this, there has been  
4 a reorganization of the committee structure and staff. About  
5 five more committees have been appointed.

6 The action plans now are developing in primary care,  
7 rural and urban health care delivery and reaching to more  
8 relevant projects. Those are a little bit superficial. They  
9 are showing intent to move into those areas, and they do have some  
10 projects that are related to them. But they are not really as  
11 comprehensive as they need to be yet.

12 Now, in improving RAG involvement, the orientation  
13 is planned for new RAG members to include a new group orienta-  
14 tion. The criticism was made that the group really needed to  
15 find out more about what was going on in Louisiana and how they  
16 could relate to them. So they are having an orientation  
17 program and a site visit by RAG going to the various projects  
18 and programs and evaluating their progress.

19 They have added more CHP and consumer and minority  
20 representation. I told you about their forming three new  
21 committees.

22 In the \$612,000 that have been gained in Federal  
23 support, these were related to the New Orleans area-wide Council  
24 on Aging, the New Orleans Sickle Cell Anemia Foundation, the  
25 New Orleans Health Development in Charity Hospital to develop

1 a statistical program.

2 And the more relevant projects that they have  
3 developed, some examples of those, are the homebound rehabilita-  
4 tion program, the continuity of care demonstration, the extension  
5 of the Lallie Kemp Pediatric Outpatient Service -- this is a  
6 nurse program -- a family nurse practitioner program and a  
7 hypertension surveillance program.

8 One of their weaknesses is that some of their  
9 projects really don't fit into their new emphasis of their  
10 plans that they have outlined themselves such as the training  
11 program for CCUICC nursing personnel, the outreach counseling  
12 program for diabetics, the care and transport of high risk  
13 neonates and the Louisiana Drug Information Center.

14 They justify these as seeing that the peril of the  
15 high risk neonate is a very first priority. And if they can  
16 accomplish this, it will not only relate a number of hospitals  
17 to the program, but they think it will bring the private and  
18 charity hospital systems together in providing what they  
19 consider to be a very scarce service.

20 You have had a staff analysis. I asked Dona if  
21 she could help tell us about how they are going to pay for  
22 these programs after RMP support is concluded. And she has  
23 given me these impressions.

24 Ongoing programs: The Metropolitan New Orleans  
25 Organ Bank Charity Hospital will continue the service. State

1 funds in Federal third party payment. The Louisiana Health  
2 Date Information Center program, State Health Officer says  
3 his office will assume this resource.

4 Tumor registry coordination and assistance -- Well,  
5 I won't read all these to you, but they have means of providing  
6 support for most of their programs at the conclusion of RMP.  
7 And they have shown recognition of the importance of this  
8 and the necessity for having someone to pick up the bill. And  
9 I have all these documented if you wish to look at them.

10 The Louisiana Regional Medical Program does have  
11 two kidney disease activities that are included in the staff  
12 review. One of them was the Metropolitan New Orleans Organ  
13 Procurement Program. And this is a local organ procurement  
14 program centered around New Orleans. And it largely relates  
15 to their renal transplant service.

16 They are requesting \$29,295 of direct costs or  
17 \$41,344 total cost for their final year of support. And the  
18 review committee that saw them that was headed by Dr. Jimmy  
19 Roberts, the health consultant, thought this was a good program  
20 and that it probably would be worthy of support.

21 They did make the criticism that no significant  
22 efforts had been made to get third party reimbursement for the  
23 cost of the organ procurement.

24 The other one that they have is a feasibility study  
25 on mass screening for renal and urinary tract disease using

1 low radioactive renal scanning. And this is for \$19,500. And  
2 the consensus of opinion is that this probably was not too  
3 good a program and perhaps shouldn't be worthy of our support.

4 . That is included under core and \$19,500.

5 Then, I have from Dona -- I asked her what they  
6 plan to do next year, and she has given me these promises for  
7 us to look at.

8 (a) They plan to demonstrate extensions of primary  
9 care services in medically under-served areas. And they have  
10 underneath that five ways.

11 They plan to have nurse extenders. And those are  
12 going to be research models of use in private care sector, in  
13 deprived rural clinics, and in urban neighborhood clinics.  
14 They are going to work with private care sectors, especially  
15 pediatricians, and they plan to have an outpatient ambulatory  
16 care in public health clinics as an extension of the Charity  
17 Hospital outpatient service.

18 They have access clinics around the parish health  
19 unit, and those would be related to the northeast Louisiana  
20 tri-parish model.

21 They plan to demonstrate the use of a Charity Hospital  
22 medical school resident in outpatient care in underutilized  
23 rural hospital. And that would be in April of 1973.

24 Mobile health clinics in August of 1973. And they  
25 have specific ways in which they hope to accomplish that.

1 And (b) -- that is their second major category --  
2 they plan to demonstrate impact of expanded third party  
3 payer such as Medicaid. And they have PAR study, a State  
4 Department of Hospitals contract, contract with the Calcasieu  
5 Medical Society, and then next to the last in primary care  
6 strategy, they plan to look into program and develop a strategy  
7 for the care of the rural and underprivileged. They have the  
8 men indicated that will do this. That will start in December  
9 or January.

10 And quality assurance, they have both the project and  
11 the workshop that they plan to use to try to evaluate quality  
12 assurance and guarantee it improvement.

13 As a 12-word summary, it seemed to me that this is  
14 an area that does have great need, that has made significant  
15 improvement, that has responded to each of the recommendations  
16 of the site review team and is worthy of support.

17 They have requested \$1,040,000. Council approved  
18 last year \$1 million.

19 I do have a suggestion to make as soon as we have the  
20 other comments.

21 Phil, do you want to talk now or after Dorothy?

22 DR. WHITE: Why doesn't Miss Anderson go along?

23 MISS ANDERSON: I think you covered it very well.

24 I would just like to mention the things that came to my mind  
25 while I was reviewing the material was their relationship with

1 CHP. And it seems like they are working a little better with  
2 CHP rather than taking over CHP's responsibilities. And their  
3 HSEA has been developed in cooperation with CHP.

4 Another area when we talk about minorities, I was a  
5 little sensitive to the fact that there are so few women on  
6 the RAG and so few women on the staff. And I think this is  
7 another area where they need to concentrate.

8 The projects are very good. Fifty-fifty.

9 DR. BRINDLEY: Did we mention the extra monies they  
10 got for the other programs?

11 MISS ANDERSON: No, I didn't. Go ahead.

12 DR. BRINDLEY: Phil.

13 DR. WHITE: I think I must be here mainly to lend  
14 some perspective to the Regional Medical Program of Louisiana.  
15 Your reviewers have given you the details.

16 I would like to give you a recall of my visit. I  
17 found myself -- and the other site visitors, I think, agreed --  
18 in sort of an encrusted reactionary atmosphere rather than  
19 just a conservative one. And I think this is important to  
20 understand because it gave rise to some difficulties in the  
21 genesis of the Louisiana program to begin with and continues  
22 to give rise to some problems.

23 These comments are not meant to denigrate the State  
24 of Louisiana. This is just the way things were.

25 I think that Louisiana Regional Medical Program was

1 looked on with suspicion from the very onset and barely got off  
2 the ground. And I think Dr. Sabatier is probably the Christ  
3 figure for the Louisiana Regional Medical Program. He was the  
4 savior indeed and was acceptable to the professions and  
5 providers of health care at that time.

6 But even he was not stalwart enough to plunge into  
7 a great deal of activity. He felt that it was not wise to put  
8 too many burrs under too many saddles at the beginning and found  
9 an acceptance for Regional Medical Programs by casting it in  
10 the image of a planning agency, a data collecting agency. And  
11 he proceeded to do this. And by virtue of that, I think he  
12 was non-threatening in that area and therefore did indeed  
13 become acceptable to the area.

14 I think that even before our site visit, some members  
15 of the Regional Advisory Group had begun to recognize that it  
16 may not be playing the role that it should. Mr. Smith was  
17 the head of a committee at that time analyzing what the role  
18 of the Regional Advisory Group should be. And he is now the  
19 chairman of that group and I think will indeed implement the  
20 changes which are necessary.

21 At the time we were there, there was sort of a  
22 nebulous shadow-like multiple-headed creature in the background  
23 which we finally came to identify as the Regional Advisory  
24 Group. We are not sure they knew what their role was. And they  
25 were not sure what their role was. And they were even a little

1 confounded on why they were there at the site visit at the time.

2 But Mr. Smith and a few others have taken leadership  
3 and at least from the written comments I have available to me  
4 have made substantial changes in the role of the Regional  
5 Advisory Group and I think are taking leadership.

6 I think their new structure clearly points out that  
7 they do have some dedicated members who will participate in  
8 the establishment of the program and hopefully evolving in the  
9 evaluation of the program eventually as well.

10 There is no need to dwell on the grantee relationship.  
11 This came out clearly in the site visit at the time. The  
12 grantee was sort of a patriarchal group that deigned to let  
13 the Regional Advisory Group meet from time to time, but not  
14 do too much. But this has been corrected, I think.

15 Minority representation -- there were some token  
16 representatives there at the time of the site visit. This, I  
17 think, has been improved and certainly needs improvement more,  
18 I think not only because it would be helpful to have their  
19 input, I think it would be helpful if some of these non-white  
20 mat on some of these groups and found out the problems that one  
21 is confronted with in trying to get the changes made in the  
22 existing systems that occurred.

23 I recall my own amazement and consternation when I  
24 moved from a simple faculty member to the dean's office and  
25 began to recognize that maybe the dean wasn't the all-powerful

1 figure that we all thought he was and that he couldn't wave  
2 a wand and create changes overnight even though he thought he  
3 could at times. But I think it would be helpful for minority  
4 groups to sit on a Regional Advisory Group for that purpose if  
5 for nothing else.

6 It was interesting, as we discussed the role of the  
7 RMP and CHP on that occasion. Neither group really knew what  
8 it was they were supposed to do. RMP had effectively filled  
9 the role of a CHP, filled the vacuum that existed. We queried  
10 a number of visitors who really felt that this was the proper  
11 role for RMP, and they weren't quite sure what the proper role  
12 for CHP was. There was just no clear understanding of what  
13 this was all about or what the relationships should be.

14 Apparently there is still some confusion existing,  
15 although a coordinating committee is in existence which will  
16 help clarify their respective areas of activity.

17 I think Dr. Brindley and Miss Anderson have fully  
18 related to you the change in direction that has taken place.  
19 Their projects now are indeed more action oriented.

20 I did not recall with great clarity what the goals and  
21 objectives were in the original application prior to the last  
22 site visit, but on page 39 of the present application as was  
23 pointed out, there are a number of pages beginning on page 39  
24 which outline their goals and objectives. I think they are  
25 clear, understandable and quite pertinent to the needs of

1 Louisiana. And if this does indeed form the framework for  
2 their action, they will forge ahead.

3 I think also that as they have reviewed their own  
4 projects, they have taken seriously the comments made in the  
5 advice letter and in other oral communications. They have  
6 clearly looked at each of their projects to determine whether  
7 or not they are relevant to the comments that are made in those  
8 letters and in subsequent advice. So they have taken to heart  
9 what was told them.

10 I think that perhaps we could be a little impatient  
11 with how they have expedited these suggestions, but I think  
12 the atmosphere has not changed that great. There may be a  
13 need for them to kind of subtly invade the care system in  
14 this State still and that perhaps a neonatal intensive care  
15 program of some sort will provide that without general  
16 threatening attitudes of any kind. Perhaps a drug information  
17 service will provide that and certainly the extension of the  
18 pediatric clinics, the nurse practitioner and so on will.

19 So although there may be some question as to the  
20 total relevance of some of their new projects, I do think it is  
21 a mechanism from which they can enlarge.

22 I guess the only exception I would take as to the CCU  
23 coronary nurse training which is something that you have been  
24 dealing with for years and years, and it doesn't seem to ever  
25 want to phase out, so perhaps somebody has to take the bull by

1 the horns and say no once in a while. And if that were so in  
2 this particular case they wouldn't need that extra \$40,000 more  
3 than they requested above the ceiling Council suggested and  
4 they could get by on the \$1 million.

5 Those are about my only comments. I would like to  
6 state that I have enjoyed being here today. I used to look  
7 forward to these meetings remarkably well, not because I enjoyed  
8 all of you so much, but the trips were always kind of exciting,  
9 the airplane rides.

10 One time I had lunch with Diana Ross. Another time  
11 I met with a Mr. J. C. Agergani who owns racing cars at the  
12 Indianapolis speedway. I think it was time before last I came  
13 in on one engine. And this time I was with a bunch of  
14 apparently Democrats for Nixon from Texas. And they were all  
15 coming for the inauguration. And there was a very festive  
16 plane ride.

17 The only difficulty was I happened to be sitting  
18 behind a rather generously proportioned lady who did not join  
19 into the festivities. And she promptly put her seat full back  
20 into my lap. And I was kind of sitting there unable to enjoy  
21 myself or the festivities and was thankful when we landed  
22 finally and she was able to put her seat back up and I got here.

23 It is nice to be here. Thank you.

24 DR. SCHMIDT: It is nice to have you.

25 The planes will probably be empty going home, I would

1 guess.

2 I am watching the clock because -- let me test the  
3 sentiment of the group on a very important issue. How many  
4 feel like they must have a cup of coffee in the next little  
5 while?

6 (Hands were raised.)

7 All right. Then what we will do, let's go ahead and  
8 get the funding level to meditate on while we go get coffee.

9 I would suggest that committee members get their  
10 coffee in cups and bring it back here and we keep working.

11 Dr. Brindley.

12 DR. BRINDLEY: We would like to recommend a level of  
13 \$1 million for one year. We feel that is a considerable  
14 improvement over what was actually granted to them last year.  
15 It is only \$40,000 less than they have requested.

16 And then they intend next year to ask review for  
17 consideration of triennial application.

18 So I would move that we recommend \$1 million for them  
19 for one year.

20 DR. SCHMIDT: Is there a second?

21 MISS ANDERSON: I second.

22 DR. SCHMIDT: There is a second. Is there a wish  
23 to discuss?

24 DR. KRALEWSKI: I have one question. The  
25 supplementary funds that were given to the region this past

1 year was that just a one year?

2 DR. BRINDLEY: Those are earmarked funds, one year.

3 DR. KRALEWSKI: They will not have a need for those  
4 funds this coming year?

5 DR. BRINDLEY: They did not say that. They indicated  
6 one of the programs -- I believe that was the pediatric  
7 pulmonary program -- that Tulane University intends to apply  
8 for funds. And the Health Service Education Programs when  
9 funds become available. And then they may try to apply for  
10 those. But that is not part of the application.

11 DR. SCHMIDT: The earmark was a one-shot deal, and  
12 they knew that. So that this application is to cover that.

13 DR. BRINDLEY: They are not applying for any more  
14 funds.

15 DR. LUGINBUHL: I would like to ask about the leader-  
16 ship of this program. They have been active since 1966. They  
17 still do not have triennial status. It is obvious that there  
18 have been problems with this program from reviewing the  
19 material.

20 The amount of money they are requesting is \$1 million  
21 for a population of 3.6 million. We just approved the  
22 Washington/Alaska program of comparable population at a much  
23 higher level, obviously a much more developed program.

24 In short, I am concerned that this population may  
25 not be adequately served by the organization as it now exists.

1 Is that actually the case, or are there reasons to believe that  
2 this will develop into a program that will really adequately  
3 serve this region?

4 DR. SCHMIDT: Phil, let me ask you to field that.

5 DR. WHITE: I was hoping to clarify that in my  
6 remarks that there has indeed been difficulty with this region  
7 because of the attitudes that existed. It has not been a  
8 lack of leadership, I don't believe.

9 Well, partial lack of leadership. Let me put it that  
10 way. It has been a lack of leadership by the Regional Advisory  
11 Group, by the citizens who were participating. I think Dr.  
12 Sabatier has been a good leader. I think the staff members  
13 that he has around him are good leaders, good in working with  
14 the groups, both the consumers and providers in the Louisiana  
15 area.

16 But there has been a lack of leadership. It has been  
17 at the level of the Regional Advisory Group and perhaps to some  
18 extent at the grantee level, too, and perhaps even to some  
19 extent at the medical school level, but not at the staff level.

20 I think that this is turning around. Clearly in my  
21 mind, it is. If we were to deny them what they have asked for  
22 particularly since the additional sums this year, \$368,000 or  
23 something of that sort for the new projects, now are action  
24 oriented projects rather than data collecting and planning ones.

25 But they would question our understanding of their problems, the

1 would question the seriousness of any advice that we sent them.  
2 they have indeed done what we told them to do and now we do not  
3 reward them by giving them substantial sums to do what they  
4 need to do.

5 DR. SCHMIDT: O.K., I see there is a need to discuss  
6 this, and I don't think we would be too well served by trying  
7 to jam this many people into the coffee place as they are trying  
8 to slam the doors. So we will adjourn now for going down and  
9 getting coffee. And I would ask the committee members to get  
10 it in a cup with a cover on it and bring it back. And we will  
11 try to reconvene here in about 10 minutes.

12 (Whereupon, a recess was taken.)

13 DR. SCHMIDT: All right, to recapitulate, then, we  
14 are talking about Louisiana.

15 We have a motion on the floor for funding level of  
16 \$1 million for one year. This is essentially exactly what the  
17 Council recommended for this year. It is \$40,233 below their  
18 request.

19 Dr. White pointed out one \$40,000 project in there  
20 that wasn't all that exciting.

21 We were discussing the funding level. And the  
22 question has been raised as to the leadership. And the point  
23 has been made that the program leadership was really quite good.  
24 It was in a very conservative, more than conservative,  
25 atmosphere, meaning the problems went much beyond the program

1 staff leadership which has been quite good.

2 Yes.

3 MRS. FLOOD: I have some concerns about the minority  
4 and really down to earth non-knowledgeable consumer representa-  
5 tion in the development of these great five pages of  
6 objectives and priorities that they developed. And whether  
7 the objectives and priorities are valid is probably not  
8 questionable.

9 Dr. White has assured me they are valid, and they do  
10 give a true picture of what need to be done in Louisiana. But  
11 my concern is then that the emphasis in apportioning funding  
12 to projects is questionable that it answers these needs that  
13 they have so well documented in their many years of data  
14 gathering. And if there was no input from minorities and  
15 consumers into the development of the objectives, then there is  
16 also no constituency to coerce or -- I won't use the word  
17 "coerce" -- to encourage the Louisiana Regional Medical Program  
18 to spend their project dollars to answer the well-documented  
19 needs, especially in the urban poor. And the rural poor, too.

20 DR. WHITE: I think the point is a valid one. It was  
21 pointed out by our reviewers there was at one time practically  
22 no minority representation at all. These data were accumulated.  
23 These statistics were compiled at a time when this was an  
24 end in itself, I suppose.

25 There have been some actions taken to improve this,

1 I think, Mrs. Flood. There is at least some minority representa-  
2 tion at the present time.

3 I think regardless of that, the most encouraging thing  
4 to me at least is it is no longer the staff of the Regional  
5 Medical Program which is defining what needs to be done, but  
6 indeed the Regional Advisory Group.

7 Now, as I was saying, it depends upon your definition  
8 of consumer, I suppose, as to whether you feel the Regional  
9 Advisory Group is consumer oriented. I think there are 17  
10 out of 44 that are physicians, and the rest are in a variety  
11 of walks of life. So perhaps there is some consumer input at  
12 least to this. Perhaps it needs improving. And I wouldn't  
13 deny that.

14 I would like to point out, though, that these people  
15 have been rather busy this year. They were attracted by the  
16 earmarked funds, and I presume spent a considerable amount of  
17 time developing what were presumably first rate programs because  
18 they were funded for those funds.

19 At the same time, they were trying to reorganize  
20 their Regional Advisory Group and have substantially done that,  
21 but need to do more.

22 So that perhaps the projects which they are now  
23 presenting to us may have suffered from a lack of time and  
24 people in developing them as fully as we would like to see.

1 the future.

2 This is the beginning, at least. And I think a  
3 fairly decent beginning in view of the circumstances that  
4 existed..

5 DR. SCHMIDT: Any other comments or questions directed  
6 at the funding level?

7 (No response.)

8 If no one wishes the floor, then I will call the  
9 question.

10 All in favor please say, "Aye."

11 (Chorus of ayes.)

12 Opposed, "No."

13 (No response.)

14 That motion is carried.

15 Joe.

16 DR. HESS: I would like to suggest that along with  
17 this recommended funding level that we include our hope that  
18 there will be further vigorous development of programs which  
19 are more effectively addressed to the health needs of the  
20 people of Louisiana.

21 I reviewed the yellow sheets here, pages 10 and 11,  
22 things that were pointed out a year ago. And there has been  
23 relatively little movement. And perhaps that needs some  
24 reinforcement along with these recommendations to try to move  
25 the RAG and the other forces there that may be tending to

1 resist what Dr. Sabatier may indeed like to do, but can't  
2 because of the internal forces. And perhaps this would help  
3 that process along, try to bring this region up to a level of  
4 funding and the kind of activities they really ought to be  
5 engaging in.

6 DR. SCHMIDT: All right, that is approval with  
7 advice about the activities.

8 Dr. Ancrum.

9 DR. ANCRUM: This is not related to the funding; it  
10 is somewhat related to what Mrs. Flood, I believe, said.

11 I don't think RMP has defined what they mean by  
12 consumer for this group. And I think frequently it means  
13 anybody who is not a physician or some health profession.

14 And one definition I saw for another program was that  
15 a consumer meant people who were eligible for the services.  
16 So that maybe this might make it a little bit better. I think  
17 she is speaking more of grass roots consumer rather than having  
18 a retired banker who is not a health professional, but not the  
19 type of consumer she is talking about.

20 DR. JAMES: I could carry that one step further to be  
21 sure the consumer might sometimes be a provider. And it  
22 depends what role he is playing in the community.

23 DR. SCHERLIS: I think the best definition I heard  
24 that excluded provider was that by Dr. Spellman. I think you  
25 recall that. He said at best a physician really can't be a

1 consumer. At best, he is a sick provider.

2 DR. JAMES: In one of the programs that is included  
3 here today, I think there is a description of providers being  
4 consumers. That is in the role that they are playing on the  
5 RAG committee. And I think that often as I have looked through  
6 many of the programs in regard to minority interests that if  
7 it is a general opinion that the consumer who represents the  
8 minority must be a grass roots level who is not knowledgeable,  
9 I think that the RAG committee would be better off not having  
10 that consumer on the board.

11 But I would like to think that this committee would  
12 think in terms of minority consumers being those who are  
13 knowledgeable in the field so that they can best contribute.  
14 And that sometimes is a physician. He might be black or he  
15 might be an Indian or he might be a Puerto Rican. But he  
16 acts in that capacity as a provider and can then support.

17 DR. SCHMIDT: O.K., I would like not to get too far  
18 into a discussion of what is a consumer for RMP purposes.

19 All right, I will take one more comment.

20 MR. TOOMEY: I think I would just like to join the  
21 crescendo which is kind of a P.S. to the action that has already  
22 been taken and say in different words than Mrs. Flood and Dr.  
23 Ancrum that with the known needs that exist in the State of  
24 Louisiana, with the opportunities that are potential through  
25 RMP, that probably are short-stopped because of the inadequacy

1 of representation of people who are in need, that everything  
2 possible should be done to encourage the Louisiana RMP to  
3 expand its services because its rate of poor people, people in  
4 need who are underserved, probably are as great as they are  
5 anywhere in the country.

6 And I think as a P.S., there should be encouragement.  
7 The encouragement should come about in terms of getting a  
8 larger representation of people who can use the services of  
9 RMP. And I think that it is a shame to say, "Here is a  
10 million dollars, you are doing fine."

11 Perhaps it ought to be, "Here is a million dollars,  
12 now go ahead and do the work necessary to expend the \$5 million."

13 DR. SCHMIDT: All right, I will accept that as a  
14 very valid P.S. to what Joe said that this is approval of a  
15 funding level with advice. And the committee has been  
16 discussing a number of points that should be conveyed to the  
17 region.

18 Thank you very much, Phil.

19 DR. WHITE: My pleasure.

20 DR. SCHMIDT: We will move on way up in the northeast  
21 part of the country to Connecticut. The reviewers are Dr.  
22 Scherlis and Dr. Ellis.

23 Dr. Scherlis.

24 DR. SCHERLIS: First of all, I should express a  
25 certain note of thanks for the various site visits that have

1 been arranged for me over the years. I think I am batting  
2 about 80 percent replacement of the coordinators after I have  
3 been in these areas.

4 And I guess among the notches that I have on my  
5 site visit sleeve would go North Dakota, Oklahoma, and as of  
6 this week, I guess, Connecticut. There is one I have missed,  
7 but that fortunate coordinator was better than you all thought  
8 so he stayed.

9 The visit to Connecticut was one which was really  
10 done with a great deal of fear and trepidation by some members  
11 of our site visit group.

12 DR. SCHMIDT: Pardon me, can you hear in the back  
13 of the room? If you ever can't hear, stick your hand up.

14 You have to kind of get within four or five inches  
15 of that mike.

16 DR. SCHERLIS: The members of our site visit group  
17 included Mr. Hiroto from L.A. I had the pleasure of being  
18 with him on another site visit previously to Hawaii. Miss  
19 Jackson, Mr. Noroian; from staff Mr. Van Nostrand, Miss Faatz  
20 who is Miss Connecticut of 1972 and 1973, Miss Woody and Mr.  
21 McKenna.

22 The visit itself was a very interesting one because  
23 the Connecticut program is a different program and not just  
24 by evaluation of outsiders, but certainly from the point of  
25 view of the group in Connecticut as well. And let me begin by

1 saying there is a great deal about the Connecticut Regional  
2 Medical Program which is excellent and deserves a great deal  
3 of commendation.

4         On the other hand, there were some aspects of it which  
5 had been subject to a great deal of discussion previously for  
6 reasons that I hope will become apparent as the discussion goes  
7 on.

8         A little reference was made before about some of the  
9 problems with Connecticut. And I think you noted its rating  
10 was bumped upward at a Council meeting. And this, I guess,  
11 bespeaks the fact there are difficulties in evaluating the  
12 Connecticut program.

13         We were there under rather unusual circumstances to  
14 begin with. And that is that they are operating within a  
15 triennium period having been approved by the Council for  
16 roughly \$2.0 million for the fourth year, \$2.3 for the fifth  
17 and \$2.5 for the sixth. And they requested an increase in the  
18 Council-approved levels for the fifth and sixth years. And  
19 therefore the site visit was made.

20         The setting for our visit was the New Haven Lawn  
21 Club. The facilities were excellent. We were told as the  
22 visits began that we were there at the invitation of the  
23 Connecticut Regional Medical Program and we were there because  
24 of the fact that they wanted to enlarge their program along  
25 the levels that I have indicated.

1           It also requested a developmental component that I  
2 will get to.

3           And early on, we were reminded that the Connecticut  
4 program has, and these aren't words of my own -- these are  
5 words that the staff and the coordinator used in describing  
6 the Connecticut program -- that we were there because this is  
7 the only program in the country that set a grand design early  
8 on and that this grand design was really what was being  
9 presented to us to enforce by our approval hopefully of  
10 increased funding.

11           And this then was the import of the meeting to either  
12 approve or not approve the grand design. It became apparent  
13 very early on -- I just want to get some highlights before I  
14 get into the details -- that there was some disagreement in the  
15 State of Connecticut as far as the acceptance of this program.  
16 The State Medical Society was represented by an articulate --  
17 I won't say an official -- spokesman, but certainly an  
18 articulate spokesman who when he was scheduled came to the  
19 head table with a suitcase. And there was a tape recorder.  
20 And he opened the suitcase to indicate the wealth of material  
21 which is circulated by the Connecticut Regional Medical Program.  
22 And this was quite a large suitcase.

23           And then he put on his tape recorder to indicate that  
24 he would use the tape recorder for his presentation. And I  
25 questioned whether the tape recorder was to be his speech or to

1 be a recording of his speech. I reminded him if we were going  
2 to listen to a speech on tape, I was prepared to leave my tape  
3 recorder there to listen to his tape recorder.

4 (Laughter.)

5 It turned out he wanted to document what he had said  
6 in some detail in case any questions arose.

7 Again, another representative speaking on a totally  
8 different project, the Emergency Medical Service project,  
9 at the conclusion of it stated he wished to use the time to  
10 make public his attitude towards Dr. Clark, the coordinator.  
11 And again began a rather strongly worded statement which I,  
12 using the prerogative of the chair, chose to stop, indicating  
13 it was not scheduled for this, and we would be willing to  
14 receive any statement in writing at the national office. I  
15 don't know whether you have received this statement or not.

16 He agreed this was the proper executive statement for  
17 the chairman to have made under the circumstances.

18 We had equally strong statements made by Comprehensive  
19 Health Planning agencies. There were two, each one of whom  
20 made very strong statements to the fact that the Connecticut  
21 Regional Medical Program was not cooperating with them, had  
22 not supported them, was not giving them an ear. And these were  
23 not just objectively given, but I think rather emotionally  
24 given.

It became apparent, though, in questioning them that

1 at no time had they really evolved any plans nor had they  
2 presented any plans to the Connecticut Regional Medical  
3 Program and that they were now being very well represented on  
4 the RAG group.

5 There were also just as strong statements made to  
6 support the grand design of Dr. Clark.

7 I am giving this introduction to indicate that people  
8 are not lukewarm in Connecticut about the Regional Medical  
9 Program. You are either for it or against it. And if you  
10 don't state one attitude or another, then you just don't know  
11 that there is a REgional Medical Program in Connecticut.

12 Dr. Clark has in his grand design divided the State  
13 horizontally so that one part of the State is allied with the  
14 University of Connecticut, referred to as UCON, the other  
15 with Yale, and that most of the hospitals in the State are now  
16 affiliated with one or the other by way of full-time coordinator.  
17 And in discussing the success of the program, Dr. Clark  
18 enumerates that over the years the numbers have grown as far  
19 as the chiefs are concerned and the hospitals are now approxi-  
20 mately 55 and some 25 hospitals. And that as he points out,  
21 the troops are marching, the numbers are increasing, and this  
22 has been going on progressively over the last several years.

23 In terms of the goals as set under the design, there  
24 is no question that one would have to indicate that there has  
25 been an amazing success of this program. The number of full-

1 time chiefs have indeed increased, the number of fully  
2 affiliated hospitals working with UCON or Yale have increased.  
3 And he used this, as he states, as a threshold of fulfillment  
4 of local medical leadership based on community general  
5 hospitals.

6 And it is this program that he wished to have reviewed  
7 that he wished us to understand and become familiar with. He  
8 used community hospitals as becoming community health centers  
9 and that the local leadership would be based on creating local  
10 medical leadership by way of the chiefs in the hospitals and  
11 that they would be the new level of medical leadership in  
12 Connecticut.

13 He describes this as remarkable linkage of the  
14 university and of the various hospitals.

15 There are sequels to our meeting. One is I have  
16 received letters from the Connecticut State Medical Society --  
17 Dr. Margulies received the original -- indicating that the  
18 words which were heard were, I guess, official for the State  
19 Medical Society as far as what was expressed at our meeting.

20 MR. TOOMEY: I didn't hear that.

21 DR. SCHERLIS: The Connecticut Medical Society  
22 forwarded a letter to Dr. Margulies stating their attitudes  
23 towards the Connecticut Regional Medical Program. They have  
24 felt that the needs of the State transcend just the full-time  
25 coordinators. They felt there are local needs they felt

1 obviously should be met and be given a higher priority than  
2 what the program has been to date.

3 Let me review our site visit draft because I think  
4 this will give a more coordinated presentation of some of the  
5 problems which came up.

6 As I said, the national reviewers have over the years  
7 been generally impressed with the concept of the grand design  
8 as I have outlined it, although there has been some obvious  
9 disagreement at times with it. But nevertheless certain  
10 criticisms were expressed in the past, and this was one year  
11 ago at the last site visit.

12 The suggestion was made that increased attention be  
13 given to the further development of outreach activities relating  
14 to primary care.

15 Other sources of funds be pursued with long-term  
16 support of university-based regional faculty. I have alluded  
17 to that.

18 That the core capabilities be strengthened and that  
19 in filling staff positions minority representation in the  
20 professional ranks should be given consideration. This has  
21 not yet, by the way, been done.

22 That the Regional Advisory Board and Executive  
23 Committee increase or change its membership to include active  
24 involvement of minorities.

25 That the Connecticut Regional Medical Program work

1 vigorously to improve communication with the Connecticut State  
2 Medical Society Comprehensive Health State Planning personnel.  
3 I have alluded to what has taken place over the years, at least  
4 as reflected in our meeting.

5 That a system for organizing the full-time chiefs  
6 be developed and that they pay increased attention to  
7 creating positive public relations.

8 I told you the reason for our being there. They  
9 wished additional support for the fifth and sixth year of the  
10 already approved Council levels for the triennial period.

11 Connecticut also wished this to be done, to look at  
12 their total program. We were there then to assess the progress  
13 they had made since the last site visit and that as I have  
14 said we review their total program.

15 The grand design has been their basic instrument  
16 for affecting change in the system of health care in Connecticut  
17 And they view their function as being essentially that of a  
18 catalyst. And there is no question that they have been somewhat  
19 successful in this regard.

20 Connecticut is divided into 10 health service areas.  
21 And basically by RHP, but this has now been agreed to by most  
22 of the other groups such as CHP, Hil-Burton, and so on. And  
23 the key to understanding their system is to understand the  
24 community hospital viewed as their base of entry into the  
25 system of care.

1 Over 40 percent of the basic program money is devoted  
2 to the support of full-time chiefs and university back-up. So  
3 this is a very heavily based university and community hospital  
4 program. It is a partnership between the medical schools and  
5 the various hospitals in the State. And as I have said, the  
6 State has been divided between UCON and Yale.

7 In this State, unfortunately, the Comprehensive  
8 Health Planning has been comparatively new and is just getting  
9 organized. There is a wide disparity as far as the effectiveness  
10 of CHP. And one of the criticisms which they have made is that  
11 they have not been given the documents to review in time.

12 There was an argument about the calendar on this.  
13 The RMP said yes they had, CHP said no they hadn't. And we  
14 have received a dossier of some exchange of correspondence  
15 which I won't have the temerity to judge as far as who was  
16 told what when.

17 Suffice it to say there could be better liaison and  
18 coordination of their functions.

19 They have set up full-time formal affiliation  
20 agreements between the community hospitals, ~~the~~ universities,  
21 and I need not remind those of you who are deans that this is  
22 a very significant support to university function. The  
23 cadre of university faculty which has been developed is large  
24 which would assist the affiliated hospitals. And the attempt  
25 to set these hospitals up as centers of excellence is really

1 the key to Dr. Clark's program.

2 Twenty-nine of the 33 community hospitals in  
3 Connecticut are affiliated with university centers -- 29 of 33.  
4 Seventeen with UCON and 12 with Yale. There were no such  
5 affiliations before the program. There are now 30 full-time  
6 chiefs receiving partial support which is up to \$15,000 for  
7 three years. The total number of full-time chiefs has  
8 increased from 6 to 50 since 1968. And then these are usually  
9 phased out after a three-year period.

10 It should be emphasized that this is not just one  
11 per hospital. These in some instances get to be 2, 3, or 4  
12 as the hospitals facilities increase and as there become  
13 increased demands for this.

14 Now, we felt that in evaluating this entire program,  
15 the only real evaluation one could give is the fact that the  
16 numbers are increasing. And there are bits of anecdotal  
17 information available. But there is no other evaluation which  
18 one can speak to. And this is, I think, trying to be objective  
19 about it.

20 The amount of money which has gone into the system  
21 is tremendous. In terms of saying what it has accomplished,  
22 what would have taken place otherwise, one can't say.

23 The affiliated programs do serve the universities  
24 well because they do give additional beds, provide for training  
25 of students, house staff, and by affiliation provide for some

1 degree of care on a stratified basis. I am sure it improves  
2 the hospitals themselves.

3 Whether or not this can be the prime mission of the  
4 Connecticut Regional Program is a significant question.

5 During the course of the discussions, Dr. Clark did  
6 indicate that he thought that the request for the remaining  
7 two years of both the university and community components  
8 were at their peak level in the next triennium would see a  
9 gradual decrease. There was some question about this, I  
10 think, in terms of how realistic this was in terms of the  
11 overall goals of the Connecticut Regional Medical Program.

12 Minority interests, I think, on RAG, it appears that  
13 there is somewhat adequate representation, but certainly no  
14 evidence that there is adequate minority representation in the  
15 professional group, no minorities in the professional program  
16 staff nor executive committee. And only one of the 24-member  
17 review and evaluation committee is a minority member.

18 I don't regard women as being members of minorities,  
19 but they are also inadequately represented. No inadequate  
20 persons of this sex are on that committee.

21 There is no question that Dr. Clark provides strong  
22 leadership. He has a very devoted, although small, but very  
23 strong program staff. And Mr. Morrissey who works with him,  
24 Mr. Bradley, these are very, we think, strong people.

25 The statement is in the site visit report that he is

1 personally dedicated to the successful implementation of the  
2 grand design. I would say that that is inadequately a weak  
3 statement of his devotion to the grand design. Dr. Clark  
4 really views the grand design as being what should be the  
5 model for RMPS.

6 And I was told this before I went there, and it  
7 certainly comes across as per his presentation of this. He is  
8 devoted to the concept. He feels it should be a model, that  
9 this is what RMP is all about, and that unless one understands  
10 the concept of the grand design -- and he was willing to come  
11 to Baltimore and spend some time with me to make sure that I  
12 thoroughly understood the grand design. And I don't mean any-  
13 thing more except that he is devoted to what in Connecticut  
14 has proved to be a very effective link. It depends on your  
15 judgment whether these are the primary needs of Connecticut and  
16 whether this should be of the highest priority of RMP. It  
17 has not been a successful organizational accomplishment.

18 The Regional Advisory Group does have six CHP  
19 representatives. We were concerned about the review process.  
20 There is a very, very, very strong review and evaluation  
21 committee which screens the projects, performs site visits,  
22 conducts technical and scientific reviews, determines program  
23 relevance and funding allocations and so well documents its  
24 suggestions that by the time it gets to RAG, I don't think  
25 anyone would have the gall to dare differ with any of the

1 recommendations of the review and evaluation committee.

2           And this was discussed in the feedback session  
3 because I think it is such a strong group and everything has  
4 been handled so effectively and the documents are so  
5 impressive, there is no way I think for RAG to really become  
6 as mature as it should in passing judgment on making decisions  
7 as far as what should go on in that area.

8           The grantee organization is Yale. And apparently  
9 this is satisfactory and in line with RMPS policy.

10           I have discussed the medical society in CHP. This  
11 is a very, very difficult relationship and one which has not  
12 been solved over the years. I think Dr. Clark's attitude that  
13 they are forming a new power base through the medical leader-  
14 ship of the community hospitals has to be taken as an attitude  
15 which he has to express in terms of what has taken place.

16           There were some projects presented to us that  
17 concerned us. There is an EMS program which is being formulated  
18 They have gathered some good data, but in questioning the group  
19 -- and Yale has been very helpful as far as getting data for  
20 many of their studies -- it became apparent that their emergency  
21 system is almost purely trauma.

22           In asking whether or not -- and here my personal  
23 bias came out -- I asked what the cardiac input was to the  
24 Emergency Medical Service program. And there was a moment of  
25 silence. And then they stated they are still in the planning

1 stage, but along the line somewhere they would get some  
2 cardiac input to this.

3 Is this your impression?

... 4 MR. ROSE: Very much so.

5 DR. SCHERLIS: And their stating that they had  
6 probably done the best job of anyone in the country as far as  
7 evaluating services in the emergency rooms and so on.

8 I asked two questions. One, if there had been any  
9 feedback of any of that data to the hospitals. And they were  
10 thinking of doing that and hadn't decided if they would.

11 They had gathered data and really hadn't been able  
12 to make use of it.

13 So I think they have a long way to go, but apparently  
14 the people who are involved with this I think can with some  
15 planning money move along in that regard.

16 I should say that one of the CHP agencies, the  
17 South Central Agency, provided one of the best reviews we saw  
18 provided by any CHP agency. There is unevenness, but this  
19 agency was a very effective one.

20 There is a peculiar aspect of their developmental  
21 request. And that is that we had presented to us two projects  
22 by two individuals which were presented beautifully in terms of  
23 what could be looked at as model types of programs.

24 One for multiple hospital ambulatory pediatric care  
25 system, the other for hospital-based medical care system for the

1 elderly by two extremely knowledgeable groups. Dr. Markowitz  
2 was one group and then there was another.

3 I am wrong. I forget. Not these two. I forget the  
4 two who presented them. But both of these men were excellent.  
5 They presented their systems, and they have been introduced as  
6 presenting model systems which the Connecticut Regional  
7 Medical Program would then submit to all of the different  
8 hospitals in the State. And they would all come in and say  
9 whether or not they could handle it. And there would be some  
10 method of determination who would get the programs. This is  
11 how Dr. Clark had presented it.

12 But in asking each of these individuals, it became  
13 apparent that each was presenting something he was ready to do  
14 and set it up for his own area. And they were both upset that  
15 this was going to go out for others to bid on.

16 They really should have been submitted as projects  
17 and would have received the whole-hearted endorsement because  
18 they represented excellent outreach programs involving the  
19 potential and in many instances good community support. They  
20 had been excellently researched and had the potential for good  
21 staffing.

22 And it gets down to how you define developmental  
23 component. We did not think these were developmental component  
24 These should have been projects which were ready to become  
25 operational.

1           We spent two full days there. And I think the  
2 committee came away with, I hope, a full understanding of what  
3 the Connecticut Regional Medical Program has been and may very  
4 well continue to be unless there is firm indication that there  
5 is time to change from having 30 or 40 or 50 or 60 full-time  
6 men in the community hospitals and having most of the funding  
7 go to the universities and that this is a time where decision  
8 had to be made as far as changing direction of the grand  
9 design of the Connecticut Regional Medical Program.

10           And we made several recommendations at the end of our  
11 meeting which included the following:

12           Number one, they should reconsider the goals and  
13 priorities in terms of developing efforts in community outreach.  
14 This sounds like what they said a year ago. Although they  
15 had developed an excellent network through their system of  
16 university-hospital affiliations, these should not be  
17 supported further as far as any expansion is concerned, but the  
18 new programs were available as shown in both their supplemental  
19 and developmental components and that these should be supported  
20 in preference to their expanding university and hospital  
21 affiliation.

22           That they have to set up some criteria for measuring  
23 the effectiveness of the full-time chief system. I don't see  
24 how one can measure it, really, but they have to at least try  
25 to do something and get some data which they at least can say

1 means it has been successful or not.

2 That they needed a more affirmative action plan as  
3 far as employment and training opportunities for minorities  
4 and women.

5 That they should make their RAG more responsible  
6 in program decision-making.

7 That they should do and we suggested a task force as  
8 far as Connecticut Regional Medical Program and Connecticut  
9 State Medical Society because this is a must if they are to be  
10 able to affect that area.

11 And that their B agencies have to come into some  
12 agreement with Connecticut Regional Medical Program about  
13 details of logistics of review. And that their evaluation  
14 needed a better coordination.

15 We suggested some levels of funding which I don't  
16 want to refer to at this point.

17 I do have to give a follow-up which came to us as a  
18 surprise -- namely, that Dr. Clark submitted a letter indicating  
19 that he wished to leave his position as of May 1st and was  
20 willing to serve until that and to be an advisor after that  
21 until they got someone who could handle his position.

22 I don't think this really reflects on any hostility  
23 or animosity at the site visit. We certainly did not feel that  
24 way. We think that in Connecticut, and we told them so, the  
25 network he has set up is a most effective one for the mission

1 that he had defined and the Connecticut Regional Medical Program  
2 had defined.

3 I can't help but feel that the obvious need for this  
4 working with the Medical Society and with Comprehensive  
5 Health Planning, this probably played a role. Of course, this  
6 is no better off than it was before. And at an open meeting,  
7 it is embarrassing to hear the sorts of things that were said  
8 at this meeting by both of these groups and by others who  
9 would have liked to have been on the program to have expressed  
10 this.

11 I would like to leave it here and then give the sums  
12 recommended after there has been additional discussion.

13 Miss Faatz:

14 MISS FAATZ: Dr. Ellis is secondary.

15 DR. SCHERLIS: Oh, I am sorry.

16 DR. SCHMIDT: Dr. Ellis.

17 DR. ELLIS: I did not have the advantage of making a  
18 site visit, but I would like to just make a few comments --  
19 maybe just really one.

20 I think that the grand design which really brings  
21 together the community hospitals with the teaching services  
22 does provide the opportunity for bringing about institutional  
23 change in the way health services are delivered to the poor.  
24 Because it will only be by utilizing the community hospitals  
25 that these kinds of people can be admitted in large numbers

1 to teaching hospitals.

2 In some of the States with which I am very familiar,  
3 one of the big problems in getting poor people admitted to  
4 hospitals is that you have no full-time staffs. We have nobody  
5 to take care of them. Medical education and health in general  
6 is poorly funded. And so we can't take them.

7 I think we would all agree that this certainly is  
8 institutional change. And what we are simply saying is that  
9 the grand design could and must be extended to do some other  
10 things.

11 Now, I have listened to the wonderful discussion that  
12 Dr. Scherlis made and really can't add much there. But I have  
13 heard over and over again that minorities have not been involved  
14 in this program and in many other programs. And it is one of  
15 the things that I spent my time with every week, at least.

16 I think that maybe one of the things that needs to  
17 be recommended in addition to what we have recommended is  
18 that there be some special consultation on how program leader-  
19 ship that is not leadership of the poor or blacks or browns  
20 or reds or poor whites -- and we don't understand the culture --  
21 on how we can communicate with those groups and actually find  
22 out what they are thinking and what their needs are. I really  
23 am not impressed that the kind of communication which takes  
24 place between the groups is done in a way that puts both the  
25 leadership of the program and the people being served in a

1 position so that they talk respectfully.

2 This is a serious problem. And I therefore would  
3 suggest the use of specialized people with special skills in  
4 cross-cultural communication to be brought in as consultants  
5 to the program director so that they can immediately move in  
6 the right direction.

7 Then, the other thing I thought it was interesting  
8 Dr. Scherlis brought it up, but he did not mention the kinds  
9 of things, you see, that we are still talking about like the  
10 need for health education in primary and secondary schools in  
11 the State. This is the medical push.

12 If you do not have community hospitals to whom these  
13 children can be referred for services, you don't get anyplace  
14 either. So it is just a constant up and down kind of thing.

15 DR. SCHERLIS: Let me respond to one point which you  
16 raise which was troublesome to me as well and to our whole  
17 group. Imagine if you will that most of the hospitals now are  
18 affiliated and indeed the full-time chiefs have been funded  
19 through Regional Medical Program. How wonderful this would be  
20 if you could utilize that network.

21 Well, Dr. Clark had about three of his full-time  
22 staff there who were working in the various community hospitals  
23 to discuss what they did in their hospitals. One such person  
24 spoke and obviously a very capable individual. And after he  
25 finished his presentation of how long he had been there and

1 what his hospital was like and how they had upgraded the level  
2 of care in the hospital, I said, "What is it that you do for  
3 which you are supported that really fulfills any of the  
4 Regional Medical Program aims in Connecticut?"

5 I would still be waiting for the answer. And it was  
6 embarrassing because the silence was absolutely formidable.  
7 I think it is the first time he had ever been asked what is  
8 the Regional Medical Program in Connecticut about. And this  
9 in many ways answers the question that you posed.

10 I think that the relationship to the community  
11 hospital can be utilized as one of the best networks I know  
12 anywhere in the country for really affecting outreach by the  
13 hospitals, for looking at a system of peer review in each of  
14 these hospitals to look at quality of delivery of care. It  
15 hasn't been done in this way.

16 These individuals in their own hospitals serve  
17 several functions. They attract house staff. They maintain  
18 training of house staff. Students rotate through. And they  
19 help teach the students. In one or two instances, maybe a  
20 few more, it may even be beyond this, but there is no attempt  
21 to even form these people into a cohesive group.

22 We suggested that there might be an organization of  
23 such directors working with Regional Medical Program to  
24 establish an organized basis when it would occur. The  
25 orientation isn't that way. The orientation is to have more

1 chiefs in the community hospitals affiliated with the  
2 universities. And it is sort of the university responsibility  
3 to seek out ones to work with them.

4 It doesn't take too much alteration to affect the  
5 sort of things you referred to.

6 DR. ELLIS: No, it doesn't. It really doesn't take  
7 much. It just takes an insight into how to program. You could  
8 pull these two things together very easily, I think, if you  
9 knew how to communicate with the people.

10 DR. SCHMIDT: Eileen, do you have any general  
11 comments before we do get a motion on the floor?

12 MISS FAATZ: No.

13 DR. SCHMIDT: All right, then, back to Dr. Scherlis.

14 DR. SCHERLIS: No comment, after all your years with  
15 Connecticut?

16 MISS FAATZ: No, I think you covered everything.

17 DR. SCHERLIS: If you differ, I wish you would so  
18 state.

19 MISS FAATZ: No, I don't.

20 MISS ANDERSON: Dr. Scherlis, did they show any  
21 interest in being flexible or adjusting their roles from the  
22 old patterns?

23 DR. SCHERLIS: We had a feedback session. And at  
24 the feedback session many of the positive points were referred  
25 to. The success of the full-time chiefs, the increasing

1 number, the good affiliation and acceptance of the community  
2 hospitals. This is an important aspect. They do accept and  
3 they do welcome this. There is no question they benefit as  
4 well as the universities do.

5 But as we pointed out to them, and I headed this in  
6 our site visit feedback as the dilemma of the site visit group,  
7 we cannot discern any attempt to set priorities as between the  
8 new programs which had been presented to us under the  
9 supplemental development component and getting more full-time  
10 chiefs. We wanted to know if he had another \$500,000 would he  
11 get another 30 full-time chiefs or would he develop some of  
12 these developmental components or fund some of the ones that  
13 had been presented. And I guess we really don't know what he  
14 would do under these circumstances unless there was some  
15 firm indication.

16 We have no idea at what point in time he will say  
17 he has enough chiefs. Because those hospitals that have one  
18 would like to have two. And those that have two would like  
19 to have three. And those that have three would like to have  
20 four.

21 And the point that we made very strongly was that  
22 as far as our recommendations are concerned, we felt that the  
23 point had now been reached, and he was told this in the feedback  
24 session, that the medical schools and the community hospitals  
25 would have to find alternate funding as far as any expansion

1 of this program.

2 Now, as far as dollar marks, we have a dilemma.  
3 Remember, I said at the beginning we were there at his  
4 invitation. We were there to view the grand design because  
5 they wished increased funding. A lot of the increased funding  
6 could go to expansion of the full-time chiefs all thrown in  
7 with these other primary projects.

8 What we recommended is that they fund these new  
9 projects, not as developmental, but as real projects including  
10 the supplementary ones. But they do this at the expense of  
11 their full-time chiefs. So we recommended no increased funding,  
12 no developmental component, but that they with their same  
13 level fund the projects and no more chiefs.

14 And I guess the response, I guess Dr. Clark sensed  
15 that in our discussion. This may be the reason for the letter,  
16 Dr. Margulies. I am not privy to the exact reasons for it.  
17 But I don't think we should consider that in our decision.

18 DR. SCHMIDT: Let me be sure I understand now. The  
19 previous levels that had been approved were going up.

20 DR. SCHERLIS: Let me tell you the full recommendation

21 DR. SCHMIDT: Yes, let's have that.

22 DR. SCHERLIS: We recommended that for the five years,  
23 they receive \$2,332,820 which is what had been approved before  
24 instead of the \$2,737,000 they had requested. And because  
25 of the nature of our recommendation that they be site visited

1 again for the next year.

2 I did this knowing full well that the request might  
3 be that I would be one of those site visit crews. And that is  
4 not a trip I would relish. But under the circumstances since  
5 this does require a complete change in their program direction,  
6 we did not feel that they should have two years without a  
7 site visit. And so, therefore, the recommendation was for  
8 one year approval and that we come back before the sixth  
9 year.

10 I don't see how else we can move into this. The  
11 grand design is there, but it has to be altered if there is  
12 to be any change at all in direction of the CRMP.

13 DR. SCHMIDT: The Council recommended for year 02  
14 \$2,332,820 as you said. And then the next year \$2.5 million.

15 DR. SCHERLIS: We are only going along with  
16 \$2,332,820 with the significant recommendations that we have  
17 made as far as program change.

18 DR. SCHMIDT: With then a site visit before the  
19 \$2.5 million year.

20 DR. SCHERLIS: Yes. I don't know how else we can  
21 handle that.

22 DR. SCHMIDT: Is that kosher now? They have been  
23 approved for the triennial.

24 DR. SCHERLIS: The Connecticut program is one that  
25 has excited a great deal of interest in both the review

1 committee and Council level, I take it. The point that even  
2 their rating gets bounced upwards at Council meeting.

3 If we approve for two years, there is absolutely  
4 no indication in sight that they would not continue as they  
5 have been, funding new full-time chiefs instead of getting  
6 involved with additional projects.

7 If you have another mechanism to assure this, such  
8 as a staff review, I would certainly prefer that to a site  
9 review. But now the fact that they are also getting a new  
10 coordinator may make it even more imperative they be seen at  
11 the end of this one year.

12 I would like to have some direction on this.

13 DR. SCHMIDT: I just want to clear the point is  
14 what he proposes legit?

15 MRS. SILSBEE: We don't have any precedents for  
16 this. But in relation to the reason the site visit was held  
17 this year, Dr. Scherlis, in terms of the fact that Connecticut  
18 requested developmental, that wouldn't automatically call for  
19 a site visit. The fact that they requested more money wouldn't  
20 call for a site visit.

21 Actually, the reason the site visit was held was  
22 because Dr. Clark requested it. And after much deliberation,  
23 we decided --

24 DR. SCHMIDT: Are you going to stick with the word  
25 "request"?

1 MRS.SILSBEE: After much deliberation, we decided  
2 the only way we could handle this request, knowing about his  
3 program, was to send a team up there to see whether any of the  
4 things that had been suggested in terms of change had occurred.

5 DR. SCHERLIS: Thank you.

6 DR. SCHMIDT: All right, Dr. James and then Dr.  
7 Luginbuhl.

8 DR. JAMES: There is something that bothers me in  
9 regard to what is afoot here. I hear you stating that there  
10 was a meeting with representatives from the State Medical  
11 Society, but he was not an official representative, he did  
12 not represent the medical society officially.

13 I wonder perhaps if there is not in this grand design  
14 an area of threat to the private practicing physicians  
15 represented by the State Medical Society that looks like there  
16 might be a town and gown takeover of the private practice of  
17 medicine that possibly could cause some anxiety among the  
18 State Medical Association people.

19 Yet, if what you are saying that the grand design  
20 does represent an institutional change in the delivery of health  
21 services, what is it all about?

22 And relative to a continuation of the old, if there  
23 could be some clarification of someone here today relative to  
24 what is the stance, s-t-a-n-c-e, taken by the State Medical  
25 Association and the CHP agencies and the other agencies in the

1 community, is it that the university and the community hospitals  
2 who are for the first time moving into delivering a community  
3 service, something that should be continued or is this  
4 something that offers a threat to private practice of medicine?

5 DR. SCHMIDT: If I might try to tackle that one  
6 myself, I think from the beginning the grand design was something  
7 that was held up by the Connecticut RMP as a model. And  
8 certainly Dr. Clark who really kind of devoted his life to  
9 this general subject of regionalization considered this to be  
10 the best way to go in Connecticut.

11 The Medical Society very early on did not necessarily  
12 agree. And indeed, they did look on this as a threat. And in  
13 the past number of years, there have been various number and  
14 kinds of steps taken by the Medical Society, including  
15 telegrams in requesting there not be any action until they had  
16 a chance to be heard. There have been special visits of the  
17 Director of RMP to Connecticut. There have been meetings  
18 up ther and so on.

19 And as someone said, the RMP really did do the whole  
20 thing for the State early on. And there was ~~not~~ a CHP in  
21 evidence.

22 What has happened gradually is that people got used  
23 to the grand design. The Medical Society and RMP are kind of  
24 settling down into some kind of a coexistence. The Medical  
25 Society is awkward about stating its case. And what really

1 happened was that the official representative didn't show  
2 at the site visit and the site visit team was a little confused  
3 as to whether they were hearing an individual doctor and  
4 chose to hear the doctor that did come as an individual rather  
5 than an official representative of the Medical Society because  
6 he had not been so designated and they were just left without  
7 this official voice.

8 CHP is struggling, and the grand design in a way  
9 umbrellas some of the things that ordinarily CHP would do.

10 I think that the site visit team is suggesting that  
11 the RMP must do some other things and not keep expanding this  
12 grand design in the way Dr. Clark might. And so we are  
13 obviously in the recommendation putting a stop to that, giving  
14 them strong advice that they implement new types of activities  
15 and do this with the funding that they might otherwise have used  
16 to further what indeed the Medical Society has in the past  
17 objected to.

18 The question you asked could be answered with the  
19 word "yes," but I don't think that anyone would necessarily  
20 imply by that yes that the Medical Society ~~was~~ right and the  
21 RMP was wrong.

22 As I take a long view of the Connecticut situation,  
23 it is that they are kind of settling down and in a little bit  
24 more, perhaps they will have settled down into a relationship  
25 that won't create all of the sparks and so on that it has in

1 the past.

2 Is that an unfair statement?

3 DR. SCHERLIS: No. I think to assume that you are  
4 going to change either the delivery of health care or make it  
5 more accessible on the basis of the network that has been  
6 described for Connecticut is an assumption. It isn't set up  
7 to do that. The purpose is not to accomplish that. And unless  
8 the goal is altered, it won't do it merely because the network  
9 happens to be there.

10 Being university based, were I a dean, I would relish  
11 the financial support that RMP is giving. I in no way should be  
12 assumed to be criticizing the value of such relationships and  
13 affiliations with community hospitals. I think it is very  
14 important. I just question whether you should use 40 percent  
15 of Regional Medical Programs money in order to accomplish that  
16 when there are other needs.

17 So you know I am wearing two hats in this as I am sure  
18 the chairman is and others around this table.

19 DR. JAMES: The only question I would have is there  
20 any evidence where there would be a takeover of the funds that  
21 were initiated by RMP, say by the universities? Is this  
22 possible? Or is it possible through any other agency? So  
23 where RMP may have initiated this and certainly if there is  
24 evidence that further chiefs would be funded, there must be  
25 evidence for additional health care needed in the communities.

1 I wonder could you comment in regard to whether or  
2 not there is evidence for continued support on the part of  
3 other agencies?

4 DR. SCHERLIS: Two responses. One is I did indicate  
5 that a certain number of these full-time chiefs every year  
6 have reached the three-year period of support. And they get  
7 supported through other funds.

8 The Blue Cross representative was there. We, of  
9 course, asked can you include into the cost of care of a  
10 patient in a community hospital the cost of a full-time director  
11 And he said of course you can. So there are other ways of  
12 funding this.

13 And I think that whether or not such sources are there  
14 is an issue. Whatever is done in the educational basis may  
15 have to be supported through the medical schools affiliation.  
16 And one could really question whether you need 29 of 33  
17 affiliated with a medical school. It may be wiser for the  
18 medical school to have a smaller number and concentrate quality  
19 in those.

20 DR. SCHMIDT: Mr. Toomey.

21 MR. TOOMEY: Yes, one question and then a statement.  
22 And let me ask the question first, please.

23 Did you have any input from the hospital end of  
24 this program?

25 DR. SCHERLIS: Yes. When the various hospital full-

1 time chiefs were there, directors of the hospital usually came  
2 with them. There were representatives from Hospital Association  
3 They spoke strongly in favor of this as you might gather they  
4 would.

5 MR. TOOMEY: The statement is really it is a strange  
6 thing, but hospitals are changing in terms of (a) moving  
7 away from the community, (b) moving in an attempt to parallel  
8 the changes in medicine which, of course, are more finite.  
9 They are greater, bigger programs, more equipment and this  
10 kind of thing.

11 The medical school is making a dual attempt as I see  
12 it at the moment which is to move ahead in terms of research,  
13 knowledge, education, and to move backwards in terms of primary  
14 care through their community practice programs. Hospitals  
15 have not achieved this yet. They are still at the end of the  
16 spectrum in which they are attempting to provide more complex  
17 and complicated services.

18 And I am really in agreement with you. This is not  
19 the mechanism to be used in order to get services to people  
20 in the community who are underserved. Because the community  
21 hospital is really now a misnomer in my opinion.

22 DR. SCHMIDT: Mrs. Flood.

23 MRS. FLOOD: Well, historically, this review body  
24 has criticized and sent strong advice to other regions who  
25 have augmented the staff of university settings through their

1 part-time coordinators of categorical areas, etc. And I see  
2 really no difference in concept from the actual formal  
3 university setting, medical school setting.

4 And then, too, this affiliate health delivery  
5 institution in the community hospital. And I just don't find  
6 any other comment to make except to firmly feel that they should  
7 be urged to discontinue this and perhaps even sooner than the  
8 triennium completion.

9 DR. SCHMIDT: Well, I don't know. I think if you  
10 look for firm evidence as to what this sort of thing does,  
11 you really get into principally the distribution of health  
12 manpower issue. And there are data that would suggest that  
13 this sort of thing might do something with the distribution.  
14 If they are putting medical students and residents across the  
15 State, then there is evidence to support the contention that  
16 this will distribute health manpower and services across the  
17 State.

18 Dr. Luginbuhl.

19 DR. LUGINBUHL: What about the effect on health care  
20 in the hospitals, though? Are medical students actually in  
21 all of these hospitals? Are these full-time chiefs of service  
22 doing teaching of students? Have they developed residency programs?  
23 Are they delivering care to the indigent in their communities  
24 or are they simply supervising the quality of care that is  
25 given to private patients?

1           What is the actual effect of these full-time chiefs  
2 in community hospitals?

3           DR. SCHERLIS: You are asking me the very question  
4 that we would like to have information on. I can give you  
5 numbers. I have tables here which show how many medical students  
6 there are in each one of these hospitals and so on. In terms  
7 of whether or not -- you notice, they are clustered around  
8 what are the two or three chief teaching hospitals. But you  
9 do get some distribution in some of the others.

10           In terms of does it affect the quality of care, I  
11 would have to assume that it must. I would assume that if you  
12 take a hospital and put in a knowledgeable individual who is  
13 going to be chief of medicine, he is going to ride herd and he  
14 will attract house officers, he will get his own house in  
15 order before he gets into teaching students from the medical  
16 school. Once he does this, then he can be thinking about going  
17 into the community.

18           The question that I raise is is this essentially the  
19 goal of the Regional Medical Program to the exclusion of other  
20 goals? I think it is good. I think it is great. Being in  
21 a medical school and needing teaching beds, I think this is  
22 fabulous. And if I could get funds from RMP, I would be after  
23 it.

24           I think, though, it is a question of the overall goals  
25 and priorities of a Regional Medical Program. Should this be

1 first? That is the only point I am making.

2 DR. LUGINBUHL: If this does become first, let me  
3 know very early on so I can apply.

4 DR. SCHMIDT: You missed out because you had been  
5 all the way back with Connecticut's grand design as one of the  
6 early programs and get it established then.

7 Of course, they defend it as vigorously on the basis  
8 of the planning of the Connecticut grand design by a number  
9 of committees and so on that they set up.

10 Bill.

11 DR. LUGINBUHL: It may be a very worthwhile program,  
12 but I really must add my voice to those that are expressing  
13 concern over the appropriateness of this being maintained in  
14 the Regional Medical Program. To me, it is an anomaly. Here  
15 you have one of the wealthiest States on a per capita basis  
16 that has put \$80 million in capital into a medical school, yet  
17 the RMP is being asked to fund their developing programs  
18 to the community hospitals.

19 And you couple with that one of the more affluent  
20 private medical schools, and again we are being asked to fund the  
21 development of community-based programs.

22 They may be excellent programs, but I really do have  
23 a very hard time with accepting that as a major thrust for a  
24 Regional Medical Program and with maintaining this. I really  
25 feel it should be phased down if not out and that there should

1 be plans for having this taken over by other funding sources.

2 DR. SCHMIDT: Dr. Thurman and then John.

3 DR. THURMAN: I would like to ask Eileen what she  
4 thinks Clark's departure will do to the grand design. Do  
5 you have a feel for that at all?

6 What I guess I am really asking is are we joisting  
7 with shadows? Is this going to collapse when he walks out  
8 the door?

9 MISS FAATZ: I don't think it will collapse because  
10 many of the influential RAG members are not mesmerized, but  
11 they believe in it as strongly as Dr. Clark.

12 However, I think it will be easier for the program  
13 to add different sorts of things, perhaps level fund and then  
14 scale down full-time chiefs in the universities and do some  
15 different things.

16 DR. SCHMIDT: They may not be addicted, but they are  
17 habituated.

18 DR. SCHERLIS: Well, the question asked the chairman  
19 of RAG by the past chairman sounded very much like a carbon  
20 copy of Dr. Clark. So I talked to the present chairman who  
21 sounds like the original.

22 (Laughter.)

23 They are totally convinced that this is the way to go.

24 DR. SCHMIDT: I am sorry, John is next.

25 DR. KRALEWSKI: I like your suggestion on the funding,

1 but I wonder if they will really do it or continue the same  
2 program they have now and not implement anything else. As I  
3 sit here, it seems to me that I have heard a good bit of this  
4 conversation a year ago and a good bit of that the year before.  
5 And the program is just going straight on in one direction.

6 And I think we had advice letters to them with this  
7 in it, didn't we, or didn't it get through Council?

8 DR. BRINDLEY: We sure talked about it.

9 MOR MORALES: If I can interject at this point,  
10 going back to previous review, as Len has indicated and some  
11 of the others, the difference in perspective in the reviewers  
12 towards this program has made it quite hard for us to gain  
13 a consistent kind of view toward it. The review committee  
14 took one position, the Council took another position. And it  
15 was a complicated and in many ways an unsatisfactory review  
16 process.

17 I think one cannot overstate, however, even with the  
18 position of the Regional Advisory Group the significance of  
19 Dr. Clark's departure. Because he describes himself as a  
20 missionary, and he is. He believes and has believed all his  
21 life in exactly what has been established.

22 The question now and one that I think you are beginning  
23 to deal with very effectively is what are the possibilities  
24 of doing something useful with what has been designed.

I was terribly disappointed sometime ago, and we

1 discussed it in one of the review committee sessions when  
2 a proposal was made for supplementary funding for Emergency  
3 Medical Services, and there was just no relationship between  
4 that request and the grand design.

5 Now, if there is to be a Connecticut statewide  
6 Emergency Medical System and you have an affiliation between  
7 university health science centers and hospitals and between  
8 hospitals, one would think it would just drop into place  
9 very naturally and produce an appropriate effect. Or if one  
10 looks at something like PSRO activities in which you have  
11 linked together institutions with somebody in them who is  
12 concerned with quality of care, it would appear to be a  
13 very appropriate kind of a setting in which to establish the  
14 AHA approach to it or some other kind.

15 We have talked with them in the past. This review  
16 committee has. So has the Council about trying to make the  
17 hospital now a part of the community and extend out so that it  
18 includes a way of organizing ambulatory services, all of which  
19 are potentialities. But I think that if there is to be a  
20 decision made on what happens in CRMP with Dr. Clark's departure  
21 with this current review process, we are at a moment when we  
22 can be effective in making some very strong advice to them  
23 about just what exactly ought to happen.

24 I think it will be susceptible. But any time you  
25 spend on it is going to be of great assistance to us. It is

1 the time to take some kind of action.

2 DR. LUGINBUHL: Is there a motion on the floor?

3 DR. SCHERLIS: Before I make a motion, perhaps I can  
4 ask -- There is a motion on the floor, and the motion that  
5 I made was that they be approved at what has been the Council  
6 level for the next year; that strong recommendations go out as  
7 we have indicated. And remember, there will be a different  
8 coordinator. And I understand the selection committee has  
9 already been or is being appointed for that representation from  
10 the Medical Society. And that the following year take into  
11 account the fact there is a new coordinator, there be another  
12 site visit.

13 I think it puts them very much on notice they are  
14 going to be looked at very hard. I think we drop down their  
15 funding, we are going to be in a position of a new coordinator  
16 coming aboard who is going to begin by antagonizing half the  
17 State by firing full-time coordinators. They are going to be  
18 phased out anyway. A group gets matured every third year, and  
19 they fall by the wayside.

20 DR. SCHMIDT: The question isn't maintaining those.  
21 It is doing the rest of it by some other means and doing other  
22 things with RMP and RMP money. And that advice can strongly go.

23 So that the motion, then, is as he said the level,  
24 no developmental component, the strong advice, and the site  
25 visit in one year.

1 Dr. Ellis, do you second that motion or not?

2 DR. ELLIS: Yes, I would like to second the motion,  
3 but I would like to make one change if he will agree to this.  
4 I think we should have very careful staff work with them so that  
5 they clearly understand the options and the things that they  
6 can do. Because I am afraid that with the difference in  
7 feeling about delivery of care, with one group feeling that what  
8 they are saying is decidedly different and doesn't relate to  
9 what Dr. Clark has done, it may destroy a very important base.

10 And I think that the staff really needs to work perhaps  
11 more closely with this than they have with other things  
12 because it does have a very important facet.

13 As I said before, there are so many places where the  
14 community hospitals, community affiliated hospitals, are not  
15 available to take poor people in. And we have all of the  
16 friction that we have in the large cities. So it is so  
17 important to keep what has been built up and to relate it to  
18 the other important aspects which we discussed here.

19 DR. SCHMIDT: I am sure Dr. Scherlis agrees with  
20 that. It is complementary to the point Dr. Margulies made.  
21 And it really is an assessment of what they have created and  
22 to build on that without destroying what they have accomplished  
23 to get at some of the pressing health needs of the State.

24 All right, Dorothy.

25 MISS ANDERSON: I was wondering if maybe Dr.

1 Scherlis' suggestion earlier about enlarging the RAG and  
2 broadening the RAG might help make this change possible, if  
3 that could be included.

4 DR. SCHERLIS: This is part of the recommendation  
5 that they do.

6 DR. SCHMIDT: John.

7 DR. KRALEWSKI: Could you repeat the advice that will  
8 go along with this again? I am not sure I understand exactly.

9 I would be in favor of some very, very strong  
10 advice like within one year show us how this program is going  
11 to lead into a broad program to improve the delivery of health  
12 care to underserved, to tie in with Emergency Medical  
13 Program that you are developing, etc., down the line.

14 DR. SCHERLIS: Actually, these are listed in the site  
15 visit report on page 27. I can refer to it very quickly.

16 The program must reconsider its goals and priorities  
17 in terms of developing efforts in community outreach and  
18 delivery of health care to inner city and rural areas. Although  
19 an enviable network has been developed through the university  
20 and hospital affiliations, the site team feels CRMP should not  
21 support further expansion of these areas. Rather, the new  
22 program directions exhibited should be supported by new  
23 program priorities.

24 Over the next year, there must be developed  
25 measurable criteria for an analysis of the effectiveness of

1 these full-time chiefs.

2 CRMP must immediately develop and implement an  
3 affirmative action plan which provides equal employment and  
4 training opportunities for minorities.

5 CRMP must take immediate steps to restore to the  
6 Regional Advisory Board its responsibilities.

7 These are listed in detail and one or two have been  
8 added in the discussion.

9 I think any new coordinator coming aboard, I assume,  
10 would receive this full site visit report.

11 I assume he would know that he isn't going to begin  
12 his first year by saying, "We are not going to follow anything  
13 they tell me."

14 Maybe I am naive in this regard, but I think if he  
15 knows he is going to be site visited in one year, he is going  
16 to have to shape up and follow these recommendations. He  
17 isn't going to have the longevity of having been there for  
18 several years and having built it up.

19 DR. SCHMIDT: Eileen.

20 MISS FAATZ: When the Connecticut Program makes its  
21 funding decisions, it very likely will not have a coordinator  
22 on board. And I would like a point of clarification. We are  
23 saying do not expand your full-time chiefs and the university  
24 counterparts. Are we saying do not expand the number of  
25 dollars you put into this thrust? Do not expand the number of

1 people supported? Do not support any additional full-time  
2 chiefs? And let those who are now being supported phase out?

3 You know, that is the sort of information that I  
4 think may be --

5 DR. SCHERLIS: May I respond to that?

6 The intent of the group would be that no new full-  
7 time chief be appointed. In effect, this reduces the number.

8 So if you were to accept that as a modification, no  
9 new additional, no new full-time chiefs are appointed.

10 DR. SCHMIDT: In other words, they stop appointing  
11 them. If the case hasn't been made for the value of these  
12 now, it never will be.

13 DR. JAMES: That wouldn't have anything at all to do  
14 with the influence that CRMP would have on encouraging the  
15 universities or others to follow suit in the developing of  
16 this kind of service in areas that have not been assigned new  
17 chiefs, would it not?

18 DR. SCHMIDT: Well, they have gone statewide with this  
19 now. And I believe that essentially all of the hospitals are  
20 tied in.

21 All right, we have a motion on the floor then.  
22 Unless someone wishes the floor, I will call the question.

23 The motion is understood?

24 All in favor please say, "Aye."

25 (Chorus of ayes.)

1 Opposed, "No."

2 (No response.)

3 All right. Thank you.

4 MR. HILTON: I probably should have made my position  
5 clear earlier except I don't like to bother the committee with  
6 such personal problems. But the Hiltons are expecting a baby  
7 sometime in the next 48 hours, and I would like to discharge  
8 my responsibility toward Washington today so that I can get  
9 back and be a delivery room daddy.

10 DR. SCHMIDT: Then, we will move to Metro D.C.

11 Joe, did you have something?

12 DR. HESS: I didn't want to prolong getting to a  
13 vote, but just one additional comment or two perhaps.

14 First, I think part of our ongoing problem with  
15 Connecticut has been that Connecticut has disagreed with us.  
16 I have been hearing the same thing. This is the third time  
17 now I have heard Connecticut discussed, the same issues were  
18 raised. And then the thrust of what we have said has seemed  
19 to have been blunted at the Council level and things sort of  
20 go on as they have been before.

21 DR. SCHMIDT: Maybe we ought to cut off the funds to  
22 Council.

23 (Laughter.)

24 DR. HESS: That there somehow needs to be a better  
25 meeting of the minds at that level.

1 But the other major point I wanted to address had to  
2 do with the recommendations. And that is to actually strengthen  
3 what is stated here in the number two recommendations having  
4 to do with the evaluation of the effectiveness of the system.

5 I had thought that Dr. Thompson and his group in  
6 Connecticut were developing one of the better data-gathering  
7 systems in the country and that I had assumed as we went along  
8 that this somehow was going to be used by Connecticut RMP to  
9 determine what the impact of their grand design was on the  
10 health care of the people of Connecticut.

11 And yet when I see the report there is apparently  
12 next to nothing in terms of evaluation, I am rather appalled  
13 when there is the talent in that State and in the grantee  
14 institution that we know is there. And what I am leading up  
15 to is I think that ought to be strengthened by saying that they  
16 ought to get if necessary more consultation participation of  
17 the people who have that kind of capability within their region  
18 to help them strengthen that evaluation aspect.

19 DR. SCHMIDT: O.K., staff.

20 DR. SCHERLIS: We did meet with them, and this was  
21 referred to.

22 DR. SCHMIDT: O.K., on to Metro D.C.

23 DR. SCHERLIS: Well, Mr. Hiroto was with us. He is  
24 on Council, he strongly supports the site visit findings and  
25 would be a voice to this group there.

1 DR. SCHMIDT: John.

2 DR. KRALEWSKI: Well, the Metro D.C. area, the area  
3 is outlined in this briefing document that is included in the  
4 report here today. It covers the District of Columbia,  
5 Montgomery and Prince George's Counties of Maryland, Arlington  
6 and Fairfax Counties of Virginia, and the City of Alexandria.

7 This is an area of a great many resources. It is an  
8 area of about 2.3 million people, an area that is rumored to  
9 be an area of high unemployment soon -- I don't know about that  
10 but anyway it has a lot of resources including three medical  
11 schools.

12 Now, this program was sponsored with the D.C.  
13 Medical Society as the grantee. And it has had a very stormy  
14 history right from the beginning.

15 At the present time, now, they are in the third year  
16 of their triennium. It has not been site visited this year,  
17 although the program has been site visited for the last three  
18 years.

19 A great deal of advice has been given to them each  
20 year. Some changes have been made as a result of the advice,  
21 but progress is very slow.

22 As I said, they are in their third year of the  
23 triennium right now, coming in for an increase in funding, a  
24 substantial increase. And the application has been reviewed  
25 by the staff here at RMPS, has been reviewed by SARP, and I

1 reviewed the application. But we did not site visit the  
2 program.

3 Last year, they requested, as you may recall, \$2.1  
4 million. After a great deal of anxiety and discussion, we  
5 awarded them \$1.1 million. And they are now coming in with  
6 an application for \$2.3 million. So it is a substantial increase  
7 again for the program.

8 A bit of the history. As I mentioned, it has been  
9 site visited many times. And each time, it undergoes some  
10 reorganization, some restatement of the goals and objectives.  
11 But they have a very difficult time really getting the program  
12 off the ground.

13 To start off with, they had their staff disbursed  
14 into many agencies. What they were doing was funding staff  
15 members in health departments, etc., with these individuals  
16 supposedly then carrying on a specific role for an RMP.

17 Unfortunately, they didn't have the strong central  
18 staff to handle that kind of activity. And they never were  
19 really getting much production out of these individuals.

20 The leadership and the core program was not strong.  
21 Dr. Wentz is a nice guy, and he is pleasant to chat with, but  
22 his leadership, I think we have to admit was minimum. His  
23 staff was disbursed, as I mentioned, into a number of organiza-  
24 tions.

25 He had some of the core staff with him at his house

1 with him in the core building. But that staff was quite  
2 ambiguous about their roles. They didn't know who they  
3 reported to. There was a great deal of dissatisfaction among  
4 them. And in general, it was just not a working unit and had  
5 never really become a working unit.

6           There was a lack of minorities included in their  
7 core staff and lack of minorities on their Regional Advisory  
8 Group.

9           To make things more complex, given that set of  
10 circumstances, the grantee organization, the Medical Society,  
11 did not give them a lot of support. And as a matter of fact,  
12 some of their regulations regarding salaries and fringe  
13 benefits, etc., over the years were quite restrictive and  
14 hindered the real advancement of a core staff.

15           Similarly, they developed a large Regional Advisory  
16 Group made up of various health agencies in the area. And as  
17 a result of the large Regional Advisory Group and the weak staff  
18 they really were unable to get the group to work as a concise  
19 unit.

20           As a result of that, they had a large number of  
21 Regional Advisory Group that didn't attend the meetings,  
22 didn't participate in setting the goals and objectives, and  
23 really in many cases were unaware of them. This is all data  
24 from the past site visit.

25           To make things further difficult, the program became

1 involved in a number of subcontracts. Again, while you can  
2 carry out subcontracts to great advantage, you can't unless  
3 you have a real strong central staff to initiate the contracts,  
4 determine what they are supposed to do for you and to monitor  
5 them. And, again, they just didn't have that.

6 So again and again the site visits come up with these  
7 difficulties. And again the program would sit down and record  
8 these suggestions from the site visit teams. They would bring  
9 their tape recorders along to the meetings. They would pay  
10 supposedly attention to the written advice.

11 And in a way they kind of remind me of some of my  
12 graduate students who have this poster that they bring along.  
13 And when they talk themselves into a corner on some issue, they  
14 have this poster they put up. And it says, "I am not sure that  
15 you understand what I mean because I don't know what I am  
16 saying."

17 This is the kind of thing we have between the  
18 Regional Advisory Group and our Review Committee here.

19 Anyway, following last year's review, we suggested to  
20 them that, number one, they bring their staff together in one  
21 cohesive unit physically if nothing else.

22 And then, number two, try to reorganize the staff  
23 into a functioning unit so they know who they report to and  
24 what they are supposed to be doing in the organization.

25 And then take a look at the goals and objectives again

1 and get a large advisory group involved and make sure some  
2 minority members get involved in this whole process.

3 Again, they reminded us of the difficulties of  
4 getting minorities involved. And we discovered that there were  
5 some available in the area and made some phone calls and  
6 brought them in that afternoon at our site visit and so we put  
7 them in contact with some of their minorities right there that  
8 day. And we had hoped that that would grow into some kind  
9 of mutually agreeable arrangement.

10 Well, we have now had this application. And as I  
11 mentioned, they are asking for about \$1.2 million increase.  
12 And the situation is this:

13 The Regional Advisory Group has been reorganized  
14 somewhat, has not been cut down, but rather has been expanded.  
15 It has been expanded in an attempt to bring some minority groups  
16 into it. And I think that is a plus, although now they have  
17 a larger group to handle and more problems organizationally.

18 DR. SCHMIDT: What is it up to in numbers?

19 DR. KRALEWSKI: Sixty-three, I believe.

20 MR. CHAMBLISS: With the alternates, it is around 120.

21 DR. KRALEWSKI: They have primaries and then they have  
22 alternates, but the alternates only come if the primary doesn't.  
23 I think 63 is their primary.

24 They have brought their staff together in one setting,  
25 and they have lost a few staff members in the process. But

1 the ones now that they have are in a closer unit.

2 The coordinator has resigned, Dr. Wentz, and has  
3 left. So they have now an acting coordinator, a fellow by the  
4 name of Choate who was there before as a deputy. And he is  
5 a pretty good guy administratively. He is a pretty good guy  
6 in terms of internal administration. That is where I think  
7 his abilities lie. And I don't think he is going to do much  
8 in terms of taking these goals and objectives and doing some-  
9 thing with the program for the community.

10 The Regional Advisory Group looks as though it is  
11 better organized than it was in the past. They have more  
12 committees formed, and they have minorities on those committees.  
13 So it shows some promise.

14 And they have been able to bring more minorities  
15 into their core staff with some changeover in, I believe it  
16 is, at the secretarial level, however.

17 They have revised their goals and objectives, and  
18 the revision looks as though they are making progress.

19 The way Dr. Wentz chose to do this after he received  
20 our advice letter was really to turn it over to RAG and form  
21 subcommittees and get them involved in the goals and objectives.  
22 And he started phasing himself out of it.

23 I think they are at the point now where they have  
24 tried to look at these, they have tried to pick out a couple  
25 of areas they want to deal with. And what they need now is some

1 kind of leadership to put the whole thing back together and  
2 make it work.

3 This is kind of how they sit today. And it is the  
4 kind of program you would like to put into receivership in a  
5 way, but there is no one that wants to receive it. And we have  
6 invested a fair amount of money in the program. And the  
7 question now is what we should do with it. —

8 As you recall last year, they had an application in  
9 for a kidney project. And that was funded. And perhaps it  
10 will continue on. And they have funding also for a  
11 pediatric pulmonary regional program. And that essentially  
12 they are tied into.

13 They have a couple of new projects that they are  
14 submitting along with the grant application this year. But  
15 they are projects essentially that are warmed over from before.

16 Really nothing new has been developed to fit into  
17 any new goals and objectives that have been developed by their  
18 Regional Advisory Group.

19 Now, as I mentioned, there has been a review by the  
20 staff here and SARP. And there is a recommendation that I  
21 would read from SARP.

22 Maybe I better wait until the secondary reviewer  
23 makes some comments.

24 DR. SCHMIDT: O.K., Bill.

25 MR. HILTON: I would add just a few things to John's

1 good overview on this. He and I -- or I was with him actually.  
2 He was chairing the site visit that he referred to to  
3 Washington. One of the first obvious positive things I noted --  
4 well, there are several positive things over last year, very  
5 small steps, however. They do talk about addressing themselves  
6 to underserved populations.

7 I recall stressing, I vividly recall stressing one  
8 of the ways that might be done would be to involved minority  
9 staff on the core staff, on the project staff, to really  
10 provide some effective tentacles into the community.

11 One thing that became very clear when we had the  
12 lady in who had been a RAG member and had not really been  
13 involved in RAG from D.C. itself, one of the things that  
14 became clear was that no one in the outside community, she  
15 told us, really had any awareness of what the Metro D.C.  
16 Regional Medical Program was all about. There was no  
17 effective dialogue. There weren't enough people from those  
18 communities who would talk to RMP. And I stressed at that  
19 time that increased staff would certainly help in their  
20 outreach efforts in the District itself.

21 The increase has been slight on the professional  
22 staff end of it. And I don't know that it is adequate to this  
23 day. And I don't believe it is adequate to this day to handle  
24 the proportion of work that they should be doing in the District  
25 in addition to the other commitments.

1 I have not heard Dr. Kralowski's funding recommenda-  
2 tions. I would suggest I favor a conservative level of funding  
3 far more conservative than they are asking for, not only  
4 because of these continuing problems, but because of the  
5 prospect of a new coordinator about whom we don't know what  
6 directions he might take. Certainly, we hope that he would  
7 bring a stronger leadership to the program than Dr. Wentz has  
8 had. I don't recall Mr. Choate very well in terms of what  
9 his abilities might be even now as an acting coordinator.

10 I need to touch base with John on something I don't  
11 understand in the application. There was some talk about the  
12 RAG disallowing responsibility for considering individual  
13 projects. Did I get that right? Was this their feeling that  
14 the RAG should not be involved in setting priority?

15 DR. KRALEWSKI: No. It was my impression they  
16 were quite involved in it at the moment.

17 Spence, you might want to comment.

18 MR. COLBURN: They review projects and set priorities  
19 and so forth through a subcommittee system for all RAG members.

20 DR. SCHMIDT: All right, John, let's get a recommenda-  
21 tion on the floor.

22 DR. KRALEWSKI: I would like to read this recommenda-  
23 tion from SARP and then ask Spence if he would make some  
24 comments on it since he stayed pretty close to this. And  
25 then we might go from there.

1 SARP would recommend that program be placed on a  
2 one-year probation and that they be funded at \$850,000 level.

3 Within that \$850,000 level, the kidney project would  
4 be funded not to exceed \$144,000 which is really what they  
5 need, and that the pediatric pulmonary project be funded at  
6 \$147,000.

7 And they recommend that no funds be budgeted for  
8 project 51, the cancer detection clinics, until they clearly  
9 establish that this project will not support basic education.  
10 It goes along with policy.

11 The developmental component be denied.

12 And that the Director of RMPS be authorized to award  
13 an additional \$200,000 to the project if he believes that their  
14 progress so merits during the year.

15 I think that this is a good suggestion.

16 Really, what we are saying is we will authorize  
17 them about \$1,050,000 and that that last year, as you recall,  
18 I mentioned they had \$1.1 million which is awfully close to  
19 this.

20 It gives them some running room and yet you give  
21 them only the \$850,000 to start so they have some indication  
22 they are going to have to make some progress before they get  
23 the other \$200,000. But the level is there.

24 Now, the probation bit, I believe the staff might  
25 clarify this for me. I believe we have had some other

1 programs on probation in the past and essentially what it means  
2 is that you have a year to really show that you have been able  
3 to reorganize the program and make some substantial progress  
4 or we are really going to stop it all at the end of that  
5 year.

6 Can I get the staff to comment on that?

7 DR. SCHMIDT: All right, Spence.

8 All right, we have a motion on the floor. Bill, do  
9 you second that or not?

10 MR. HILTON: Yes, I do.

11 DR. SCHMIDT: All right, Spence.

12 MR. COLBURN: I really have no additional comments.  
13 I think the overview was very good.

14 We did question the terminology used, the word  
15 "probation" in SARP, and really didn't come up with any  
16 defined definition of what it means. But essentially this was  
17 the intent.

18 DR. SCHMIDT: I think we will say that probation  
19 means at the end of a year obviously there will be a site  
20 visit and that if substantial progress has not been made  
21 toward meeting the goals set out in the advice given, the  
22 program will go to zero funding.

23 MR. HILTON: Mr. Chairman, have we ever canned one  
24 of these things?

25 DR. SCHMIDT: Well, in previous times, the Director

1 of Regional Medical Programs has in effect said this to  
2 regions, yes. I am not sure we have ever kind of officially  
3 used the word "probation." There have been a number of regions  
4 combined, as you know, and in effect phased out and phased  
5 into a larger region.

6 I personally see nothing wrong with saying this.

7 MRS. SILSBEE: In a sense, isn't this the third year  
8 of its triennial support? By putting that probation in, you  
9 are really making a stronger message than you would be by just  
10 talking about this year.

11 DR. SCHMIDT: Mrs. Flood.

12 MRS. FLOOD: May I ask a question?

13 DR. SCHMIDT: Please speak into the mike.

14 MRS. FLOOD: They were budgeted for \$787,000 and  
15 \$800 for staff. Did they expend that in year two, this current  
16 year, entirely?

17 MR. COLBURN: I don't know what their exact rate of  
18 expenditure is. But they don't expect to have any funds left  
19 over. About \$200,000 of that goes into contracts. \$195,000.  
20 So it is about a \$500,000, \$600,000 for the staff.

21 MRS. FLOOD: Is that actually staff?

22 MR. COLBURN: Staff, some consulting activity, rent,  
23 that type of thing.

24 MRS. FLOOD: My concern was that the recommendation  
25 of the SARP was a potential expenditure in kidney and a

1 potential expenditure in pediatric pulmonary of \$290,000. And  
2 if they were expending \$787,000, it didn't add up to \$850,000.

3 MR. COLBURN: Now, this is a reduction of funds.

4 MRS. FLOOD: Yes, but I mean it will actually mean  
5 also cutting staff.

6 MR. COLBURN: It is going to require some hard  
7 decisions. They will not necessarily have to cut staff, but  
8 they will not be able to fund all their activities within the  
9 period of continued support. There was a project which was a  
10 number one priority which they wanted to renew for a year.  
11 And they will not have any funds for contracting activities in  
12 new areas if they continue to keep the same level of staff  
13 support.

14 DR. KRALEWSKI: They will have four vacancies they  
15 can fill with that level.

16 DR. BRINDLEY: And they can get another \$100,000 if  
17 they do a good job.

18 DR. LUGINBUHL: Is it really feasible to zero fund  
19 a program? Is that actually a political possibility?

20 DR. SCHMIDT: Sure. The President ~~is~~ talking about  
21 doing this.

22 (Laughter.)

23 DR. LUGINBUHL: I am not sure that answers the  
24 question.

25 DR. SCHMIDT: The answer is yes.

1 DR. LUGINBUHL: The other question I have is who is  
2 going to be threatened and who is going to be challenged so  
3 that they do address the serious problems of this program?  
4 You have no coordinator at this point. You have a very large  
5 RAG, 65 or 70 people. And in my experience, large groups  
6 rarely are able to seize initiative and direct a program.

7 There has been a serious problem, I gather, with the  
8 grantee. It is the Medical Society of the area. And they have  
9 clearly not shown leadership. Who is going to respond to  
10 this challenge that we are placing on this program?

11 Are we simply going to have no one to respond? And  
12 should we think about other measures such as merging the  
13 program into another program or trying to get another grantee  
14 or other devices to strengthen management?

15 DR. KRALEWSKI: I didn't mean to indicate that the  
16 Medical Society at the moment is not supportive. In the  
17 initial years, they were not very supportive. And as a matter  
18 of fact, in our site visit last year, they had a changeover in  
19 a leadership of the Medical Society. And they at that time  
20 indicated a great deal more interest in the program. And I  
21 think that they will come through on this.

22 I also think that RAG, if what I read in this  
23 application has any bearing on the truth, will initiate or  
24 exhibit more leadership than they have in the past as they become  
25 more organized.

1 It is iffy, and I don't know. But I think that is  
2 where it will come from.

3 DR. SCHMIDT: Dr. Ellis.

4 DR. ELLIS: I would just like to ask one question.  
5 When we made the site visit before, there was a woman physician  
6 there who Dr. Wentz told us really worked to coordinate all of  
7 the programs and make the changes as had been suggested several  
8 times. What happened to her?

9 DR. KRALEWSKI: I believe you might be referring to  
10 Dr., I believe, Woodside is her name. And she is no longer  
11 with the program. But as I understand it, she is one of the  
12 candidates for the coordinator's job and I think that probably  
13 would do a good job if they can get her.

14 DR. SCHMIDT: Spence.

15 MR. COLBURN: That is correct. Dr. Woodside is a  
16 candidate. They have had a search committee. They interviewed  
17 about, or they considered about eight candidates. And this  
18 is a search committee of the RAG. And they made the recommenda-  
19 tion to the grantee and gave them three candidates that would  
20 be acceptable to them. And the grantee has interviewed them  
21 all. And there is some indication, although it is not  
22 official, that Dr. Woodside is the first choice.

23 However, due to the uncertainty of the future of  
24 RMPS right now, she is hesitant to make the decision. I think  
25 if in the future it becomes evident that RMP will remain in

1 business that she will accept the position. I think she is  
2 interested in the job.

3 The question was where is she now? She is at  
4 George Washington.

5 DR. SCHMIDT: Are there other issues?

6 MR. COLBURN: I wonder if the committee has a  
7 reaction to the size of the RAG or has any definite recommenda-  
8 tion or suggestion to make to the program. Because this is  
9 kind of a --

10 DR. SCHMIDT: My reaction is that across the country  
11 there are some large RAGs that are effective by virtue of their  
12 being advisory in nature. They give advice and consent. That  
13 is all a very large group can do. The successful ones have  
14 very sound subcommittee structure that does the work.

15 And a large one like this can meet two or three  
16 times a year and vote yes or no. But the measure of the  
17 effectiveness, the strength to which the individual RAG  
18 members in groups of six and eight and ten get at the work of  
19 the program and the size of the RAG per se isn't as important  
20 as what they do on the subcommittees, what type of subcommittees  
21 they are and what effect they have on the program direction in  
22 some way.

23 MR. COLBURN: But this RAG does have the ultimate  
24 system and has a volume of about 120 people that are eligible  
25 to serve one time or another either in the primary capacity or

1 alternate capacity.

2 There is a jeopardy, I feel, by accepting this  
3 alternate system. You dilute continuity.

4 I just want a reaction.

5 DR. SCHMIDT: The alternate thing doesn't sound --  
6 everyone on the group who has a serious concern about that  
7 alternate system please raise your hand.

8 (A number of hands were raised.)

9 We could convey to them the weakness of not a 60-man  
10 RAG per se, but certainly 120.

11 MR. NASH: I think one of the problems to the RAG  
12 is that each member has to represent an organization. This is  
13 where the alternate system comes in.

14 MR. COLBURN: It is not each member, but it is a  
15 high percentage. It is probably 85 percent of the membership  
16 institutionally affiliated or an agency or something of this  
17 nature. That is the basis for the RAG.

18 DR. LUGINBUHL: Do they have a strong executive  
19 committee?

20 DR. SCHMIDT: Is there a strong executive committee  
21 of the RAG?

22 MR. COLBURN: Yes.

23 DR. LUGINBUHL: How large is it?

24 MR. COLBURN: I think it is seven members.

25 MR. HILTON: I think Bill's question is he asked

1 how strong.

2 MR. COLBURN: They are meeting more frequently, and  
3 I think it is becoming stronger. Some of the chairmen of the  
4 subcommittees are new and have shown a lot of interest and  
5 promise.

6 DR. SCHMIDT: John.

7 DR. KRALEWSKI: I think the whole question over the  
8 Regional Advisory Group and how functional it will be is really  
9 one that is only going to be answered after they get the  
10 core organized. If they organize a core, I think they will be  
11 able to handle that large RAG group without any trouble and  
12 organize them well and get them to participate pretty well and  
13 an executive committee to do the same thing.

14 At the moment, they don't have that organization.  
15 And as a result, you have got a disorganized 63 or 119 or whatever  
16 shows up at the meetings coming in. And that is difficult.

17 Now, on the other hand, during our site visit the last  
18 time, we visited with a number of the individual RAG members.  
19 And there are some real strengths in that group. And I think  
20 that these strengths will come out once that second level  
21 group gets organized. And I suppose that is really where we are  
22 placing our bets.

23 DR. SCHMIDT: Spence.

24 MR. COLBURN: Just a correction. There are 13  
25 members on the executive committee. And the form indicates

1 they only met two times last year, although I know they  
2 have met more recently than that since July.

3 DR. SCHMIDT: That is not a very strong committee.

4 MR. COLBURN: It is really on the threshold.

5 DR. SCHMIDT: O.K., we have a motion on the floor  
6 for probation for one year, site visit at the end of the  
7 year, \$850,000 level with the director having the authority to  
8 add to for good behavior and progress during the year if there  
9 is a strong coordinator who does indeed need the money to  
10 advance the good cause of the program with zero funding for  
11 project 51 unless some substantive issues are answered by the  
12 program.

13 With this, they would fund the kidney project at  
14 no more than \$144,000 and the pediatric pulmonary at \$147,000.

15 Are there questions to the motion?

16 (No response.)

17 Is that the motion?

18 DR. KRALEWSKI: Yes, sir.

19 DR. SCHMIDT: All right, then I will call the  
20 question. All in favor please say, "Aye."

21 (Chorus of ayes.)

22 Those opposed say, "No."

23 (No response.)

24 And that motion is carried.

25 DR. KRALEWSKI: Shall we rate this one? Do we rate

1 all of them or just the ones that are site visited?

2 MRS. SILSBEE: Rate them all.

3 DR. SCHMIDT: Heretofore, we have rated them all.

4 SARP did rate it. They rated it down if you look on this one  
5 sheet here.

6 DR. KRALEWSKI: Right.

7 DR. SCHMIDT: Metro D.C., SARP, 176 from 207.

8 MR. CHAMBLISS: I might point out it is your option  
9 to accept or rerate. We leave that entirely to the Committee.

10 DR. SCHMIDT: Let me ask just speaking for myself,  
11 I could hold out through North Dakota. Would the Committee  
12 like to go on?

13 DR. BRINDLEY: One more.

14 DR. SCHMIDT: All right, Miss Kerr.

15 MISS KERR: I am pleased that you did because I  
16 know Dr. Scherlis has to leave.

17 Let me just say that the review materials and I  
18 ended up in the same place finally late Saturday.

19 North Dakota Regional Medical Program and I have  
20 gotten acquainted between the hours of 3 and 6:30 this morning.  
21 But I feel fairly well acquainted with it, and I am glad that  
22 Dr. Scherlis who was chairman of the last site visit team in  
23 December of 1970 is a secondary reviewer and also Dr. James.  
24 And I have asked Harold O'Flaherty from the Mid-Continent  
25 Branch Operations Officer to join us because he has spent so

1 much time with this region in the last year.

2 First, let me tell a little bit about North Dakota.  
3 North Dakota is the most rural State among the 50 with a total  
4 population of 618,000 is all. I was amazed. Three percent  
5 Indian population, 3 percent non-White population, average of  
6 9 people per square mile. And yet I look at the available  
7 physicians and registered nurses and combined registered  
8 and licensed practical nurses, and I will bet you North Dakota  
9 is better off than any other State I know of as far as ratio  
10 is concerned.

11 But they do have geographic problems. And the  
12 capital, of course, is at Bismarck which is in the south central  
13 part of the State. And Grand Forks is where the Regional  
14 Medical Program is based. And that is in the very northeast  
15 part of the State.

16 And I tell you this because the grantee agency is  
17 located at Bismarck. And the grantee is North Dakota Medical  
18 Research Foundation which is a subsidiary of the State Medical  
19 Society. And so there is some distance between the grantee  
20 and the Regional Medical Program based at Grand Forks in which  
21 city also is the University of North Dakota which is the  
22 fiscal agent for this Regional Medical Program, although this  
23 seems to be working very well.

24 This is an anniversary review prior to triennium.  
25 There were some problems, and I would like to identify those

1 as they were shown following the last review.

2 Early in the process, the RAG was made up of physician  
3 period. And, of course, this was questioned, and they were  
4 advised to broaden their advisory committee.

5 The staff have characterized the Regional Medical  
6 Program as being ruggadly individualistic. And I think I  
7 would have to agree.

8 To date, the project that had been funded had  
9 been centered around providing continuing education for the  
10 physicians. There was some continuing education for nurses,  
11 however there was no nurse educator or nursing service input  
12 into these.

13 The offerings were developed by the physicians for  
14 the nurses. So there was concern about domination of the  
15 program by the State Medical Society. There was concern about  
16 the failure of the region to delineate an action panel which  
17 includes time frame objectives and terminal points of evaluation

18 The failure of the program to recruit a deputy  
19 director and an assistant director for management planning and  
20 evaluation.

21 Another concern was the lack of involvement of  
22 minority group representatives on the program staff in the  
23 Regional Advisory Group in the committee structure, and it was  
24 felt that the Regional Medical Program had not developed its  
25 activities in terms of changing RMPS mission.

1           Therefore, at that time, it was not accorded triennial  
2 status. It was interesting to note that when Dr. Arneson  
3 became the coordinator in August of 1972, in his letter, cover  
4 letter, for the proposal on October 27, started out by saying  
5 the Regional Medical Program is at a critical stage in its  
6 growth, faced with problems that verge on dilemma.

7           And having reviewed what has transpired between  
8 then and now, I don't think he would make that statement  
9 quite so strongly, at least.

10           There have been minimum of six staff visits out to  
11 assist this region. And it would seem to me that they have  
12 responded pretty well to the problems that were identified  
13 at that particular time.

14           They do have a new executive director in Dr. Arneson,  
15 as I said. And he was appointed in August of 1972. Apparently  
16 his public relations are superb. He evidently knows the  
17 State real well and has good contact within the State. And  
18 he works well with the core staff.

19           He by his own admission is not as competent in the  
20 field of budgeting and finance as he would like to be.

21           Just today since having arrived here, there is informa-  
22 tion before me that says that a deputy director and assistant  
23 director for management planning and evaluation has been  
24 employed as of this month and also there was a third person  
25 employed as director for community and public relations which

1 gives them, as I counted, a total core program staff of  
2 18 including 5 secretaries which means 13 highly prepared  
3 professional people.

4 In speaking of the program staff, I would have to  
5 say at the risk of being called a feminist which I profess  
6 not to be, I do think a look at the differentiation of  
7 salaries and level of preparation on this staff between the  
8 men and women is quite remarkable.

9 At the time, it was thought that tensions existed  
10 among the several CHP B agencies and the RMP. Apparently  
11 since Dr. Arneson has come aboard, these relationships have  
12 improved considerably. And there is much support, there is  
13 mutual representation on the respective advisory groups, and  
14 they seem to be working much better together.

15 At that time, the objectives were felt to be vague.  
16 I note by the material that they do have them delineated.  
17 The goals are within keeping of the mission of the RMP.

18 They had not at this morning's reading shown too  
19 much progress in the area of setting priorities. However, in  
20 the information that came to me today, they now have set  
21 their priorities.

22 The review process was not certified because of  
23 several major identified deficiencies at the last time in the  
24 staff observations. However, the information before me today  
25 says that their review process has been approved.

1           The CHP agencies were involved in reviewing the  
2 proposal prior to the time it was admitted. And of the four  
3 who responded, three were very supportive. One felt that they  
4 could not support the funding for four projects requested,  
5 and I think this needs some explanation in that it was  
6 determined early that this Regional Medical Program had much  
7 to do to get its house in order. And I think it was not felt  
8 that it probably could do it as readily as it has nor as  
9 rapidly as it has. And so at that time, it was recommended  
10 to them from the staff that they may want to consider spending  
11 the next year picking themselves up by the bootstraps rather  
12 than to get involved in a lot of new projects.

13           However, as they moved along and felt themselves  
14 that they were maturing, it was the RAG itself that identified  
15 four projects which they would like to be pursued and for  
16 which they would like to request funding.

17           So again it was a CHP B agency in Bismarck which was  
18 the one before that was a little cantankerous, but of the four,  
19 this was the only one that had reservation about this particular  
20 proposal.

21           All the projects which they had undertaken before were  
22 continuing education as I mentioned earlier. All of those  
23 have been taken over by other sources of funding. So they are  
24 really in essence starting from scratch at this point in time  
25 in their request for funding.

1            Their third year, they received funding at the level  
2 of \$323,401. At this particular anniversary review, they are  
3 asking for \$707,025 with no identification as far as develop-  
4 mental component.

5            In Dr. Arneson, it would seem that they have a person  
6 who is going to be able to provide better leadership in a  
7 better atmosphere. And he has a core staff evidently that are  
8 highly motivated, I would say fairly sizable in number for the  
9 size of the operation to date. However, I do need to draw  
10 attention to this group. And I have strong feelings about  
11 this in view of the adequacy of the review committee about the  
12 lack of minority representation. And it was treated, I  
13 thought, quite adamantly last time to my disappointment. And  
14 perhaps I am a little biased on it because it was from my  
15 presentation last time relative to it.

16           But I have heard this afternoon three or four times  
17 we have talked about regions where the minority representation  
18 is noticeably lacking or absent. And yet I haven't heard that  
19 adequacy today. But this particular region has been told  
20 about this a number of times, and we still find only one  
21 minority on the RAG. And this is an American Indian.

22           There is no minority representation on the program  
23 staff or among the committee of which there are two and  
24 provision for others as needed.

1 coordinator evidently are working very well together. And  
2 they have set out and accepted the policies of their own and  
3 describe their roles and relationships. And it seems to be  
4 working well. So this is apparently a major improvement  
5 over the last, and they did follow the recommendations.

6 So their review, their technical review process  
7 has been approved. Their relationships with CHPs are  
8 considerably better. The policies on the relationships of  
9 the coordinator, Regional Advisory Group, grantee organizations,  
10 seem to be moving very smoothly.

11 It is my overall opinion that it has made an  
12 about face. It has found other funding for its formerly  
13 ongoing programs. And in submitting its request for funding,  
14 the funding would cover program staff and four projects.  
15 Program staff of this \$707,000, \$411,000 of it is for program  
16 staff which is 7.6 percent which seems pretty heavy. However,  
17 they have also asked funding for four projects. And just  
18 grossly, those are Emergency Medical Services, Regional  
19 Extension Center for Rehab Services, communications to serve  
20 diabetics and educational center for allied health personnel.

21 They have in their priorities put Emergency Medical  
22 Service assessment No. 1, asking \$63,241. They have put the  
23 education center for allied health personnel No. 2, the  
24 regional extension center for Rehab Services No. 3, and  
25 communications for diabetics No. 4.

1           The EMS would be an assessment in feasibility and  
2 the educational program for allied health, I would like to  
3 speak to in a positive manner because this would be done with  
4 North Dakota State School of Science at Wahpeton. It is not  
5 for preparatory programs. They have many ongoing preparatory  
6 programs at less than the baccalaureate level. The purpose  
7 for this is for in-service education of allied health  
8 workers. And they have developed a good network to get this  
9 out throughout the State, take it where the workers are,  
10 rather than require that they come into a central place for  
11 continuing education which is too often impossible for many of  
12 our people as I know from where I sit in our State.

13           So they have asked \$707,000 for program staff and  
14 for these four projects. Because they have recently made  
15 these changes, although both were good, before I make a  
16 recommendation for funding level, however, I would ask Dr.  
17 Scherlis and then Dr. James and Harold O'Flaherty if they  
18 would have any comments.

19           DR. SCHERLIS: Will you reverse that and ask Dr. James  
20 first?

21           MISS KERR: All right.

22           DR. JAMES: Well, my comments are going to be very  
23 few for the first time. However, I was very much impressed  
24 to learn of the complete about-face that the new director of  
25 North Dakota RMP has taken.

1 I think perhaps that if we had had one of the  
2 relief maps that were passed around, we could really see the  
3 vastness of the terrain in North Dakota because I think it  
4 like Alaska and so forth probably offers the greatest problem  
5 toward the dispersion of services in the area and because  
6 of the paucity of the population. Their clusters of population  
7 are into several areas.

8 I think that, too, the efforts that have come about  
9 in the development in the proposal of the four new programs  
10 involving all the CHP B agencies which was not before, I think  
11 a part of their program probably lends support to the fact that  
12 there is going to be more community involvement. Because I  
13 had understood that prior to this time there was a tremendous  
14 hold on the organization through the State Medical Association.

15 I would have to say something in regard to minority  
16 representation when one looks at the figures. That is if  
17 the Census people counted everybody because we are well aware  
18 of the fact that a lot of people just don't get counted. So  
19 I don't know whether or not there are 16,000 Indians or 2,500  
20 blacks in North Dakota or not. But anyway, we have to take  
21 what the figure says. It says that. But I would have to  
22 strongly wonder how many people on the reservation still  
23 haven't been counted or vice versa.

24 But the fact of it is that you can only have in  
25 this community a 3 percent population. And I am not willing

1 to say that everybody should be represented on any kind of  
2 Council or anything by a quota. That is out as far as I am  
3 concerned. But I certainly believe that because there is  
4 an Indian, large Indian population that certainly the  
5 organizations should be represented.

6 I understand that the Indian is a very intelligent,  
7 highly articulate person who is a representative of the  
8 Indian Council.

9 MISS KERR: Chief.

10 DR. JAMES: He is a chief? He is a big man.

11 Well, he is President, then, of the Indian Council.

12 MISS ANDERSON: That changes frequently, though.

13 DR. JAMES: I would just simply echo the sentiments  
14 I think I hear you stating in that apparently after many  
15 years of really being sort of stymied that this program  
16 looks like it may begin to take off. I am especially impressed  
17 with the cooperation between the medical school and I believe  
18 the North Dakota State school at Wahpeton.

19 MISS KERR: Yes.

20 DR. JAMES: To establish the residency training  
21 program, the internship program, to bring the medical students  
22 again out into the community, into a community network, which  
23 as far as I am concerned is combined also with general  
24 education. And I think that this will have a tremendous  
25 effect on the distribution of health manpower. And I believe

1 this is one of the areas we are really confronted with --  
2 distribution.

3 I have no other comments to make.

4 MISS KERR: Len, would you excuse me if I make just  
5 two comments before you?

6 DR. SCHERLIS: Go ahead.

7 MISS KERR: I neglected to say that the advisory  
8 committee has been expanded from 16 physicians historically  
9 to 39 members, broad representation from all health professional  
10 from community people, from consumers, and so forth. There  
11 are 16 physicians on it, one from each of the ten, I guess it  
12 is, county medical societies. And that doesn't seem unreasonable  
13 I felt.

14 And I was very much impressed with the change that  
15 has been made in the Advisory Group.

16 The other thing I wanted to say is of any bylaws  
17 I have ever read anywhere for any organization, I think these  
18 are the most outstanding, the ones they have recently. They  
19 rescinded their original bylaws, and they have a whole  
20 new set of bylaws. And they are just worth reading. I think  
21 they are well done.

22 DR. SCHMIDT: I hope you will forgive me if I just  
23 interject a comment here. I was sort of amused.

24 I think a relief map of the State of North Dakota  
25 would be a waste of money. The highest point in the State of

1 North Dakota is in the Turtle Mountains up near Bottineau,  
2 North Dakota, up near the Canadian border. The lowest point  
3 is in the Badlands in the southwestern corner. The difference  
4 in those two heights is less than the height of the John  
5 Hancock Building. And it is a lot of land area, though, I  
6 will agree.

7 Leonard.

8 DR. SCHERLIS: When we made our site visit to Grand  
9 Forks, the point you just made was brought home to us because  
10 when we went out that evening to Dr. Wright's apartment, as  
11 we approached it, we were struck by the fact that it was one  
12 of several units in a large brick building in which there wasn't  
13 a single window outside. And this was built on the basis that  
14 everything faced inside where they had built for all of the  
15 units an environment of plants and some greenery and some  
16 water. And it was the only place I have ever been where you  
17 effectively insulated yourself from the outside, both by view  
18 and everything else. Everything faced in instead of out.

19 And if you have been out there, you would know why  
20 you faced in and not out as you pointed out.

21 When we were there, the program was totally  
22 dominated by the Medical Society. Dr. Wright provided a very  
23 strong leadership by virtue of the fact that he in the State  
24 was one of the strongest people medically. I think his plan  
25 as far as either subregionalization or CHP B agencies was to

1 have the county medical society serve for the B agencies and  
2 the State society for the A agencies.

3 But anyway, it is very, very medically dominated.

4 After a feedback session which I remember very well,  
5 he thrust his index finger in my chest and told me that you  
6 people from Washington just don't know what is going on out  
7 here.

8 As we drove to the airport, he obviously didn't get  
9 any happier because we had a minor accident.

10 I think the feeling out there then was that they  
11 knew what they were going to do with their program and didn't  
12 want to have any direction. And I am impressed with what you  
13 have described in terms of new direction.

14 I was interested did we know anything about the  
15 Medex program. Is that being funded through RMP at the present  
16 time? Because they were very excited about it then because they  
17 make reference to it. But I don't know who is funding it.

18 MR. O'FLAHERTY: Department of Labor.

19 DR. SCHERLIS: It is being funded through them.

20 Also, at that time that was the only Regional  
21 Medical Program that wasn't receiving Government funds for  
22 overhead.

23 MISS KERR: It is asking for them.

24 DR. SCHERLIS: It is now so they have learned a great  
25 deal.

1 I think the change in direction is apparent. The  
2 programs do show outreach. They have always had good physician  
3 educational programs, and they have had a base for developing,  
4 I think, further ones. And I would be interested in what the  
5 financial recommendations are going to be.

6 I think the document at least indicates a  
7 significant change. I don't know Dr. Arenson, but the  
8 document would reflect a change which is a significant one  
9 from essentially a pure county medical society or State  
10 medical society based program to a broader base.

11 MISS KERR: It certainly reads a great change.

12 DR. SCHMIDT: Harold, do you have anything to add  
13 to this discussion?

14 MR. FLAHERTY: I think the group has very aptly  
15 depicted the issues, the growth and again some of the weaknesses  
16 that are apparent within the North Dakota Regional Medical  
17 Program.

18 They are inordinately more outreach oriented, and  
19 there is a sincere desire on the part of the staff to change  
20 the image here as well as to do something tangible in the State  
21 of North Dakota. And I must add when Dr. Arneson first came  
22 here, he met most of the key RMPS staff. He had been a  
23 practicing surgeon for a while, for a long time, and left the  
24 staff with a mixed impression. I guess that would be kind.

25 But he has stuck to it. He has engrained himself in

1 the process and has learned a great deal and is again very  
2 much committed and believes very much in the concept of  
3 participative management. He takes his staff, and they sit  
4 around the room and they manage by group style. He has gone  
5 from one end of the continuum almost to the other.

6 And I was telling him the last time I was there I  
7 would sure like to see North Dakota hit a balance between the  
8 complete participative management and management by fiat which  
9 had been the case for four years previous. But I think we  
10 have some reason to be encouraged.

11 I met this summer with the Board of Directors of the  
12 Medical Research Foundation, the group that tenaciously had  
13 clung onto this program and went over with them the RAG grantee  
14 policy statement. And it was their perception that they  
15 could live with it, and they have adopted it, which is before  
16 you in the application, the set of rules that are most pragmatic  
17 for a State such as North Dakota.

18 Their house is in order with respect to the RAG  
19 grantee policy. Representatives from Grants Management Branch  
20 have reviewed this and have echoed Miss Kerr's sentiments  
21 with respect to the efficacy and feasibility of the bylaws.

22 They need to lay out for themselves a three-year  
23 plan which we should see one year hence and time frame their  
24 objectives and to build in more of a viable system for  
25 evaluation. But they are well on their way to doing this.

1 DR. SCHMIDT: O.K., let's get us a recommendation  
2 then.

3 MISS KERR: All right, because of these areas that  
4 still need some strengthening and because of the areas that  
5 already have been strengthened and because there is a feeling  
6 that perhaps they will be expending a great deal of time inhouse  
7 still to continue strengthening themselves, I am recommending  
8 funding at the level of \$525,000.

9 DR. SCHMIDT: This is a one year?

10 MISS KERR: Yes.

11 DR. SCHMIDT: And then they will be coming in.

12 All right, then, the secondary reviewer was Dr. James.  
13 How does that hit you?

14 DR. JAMES: I was looking at the funding of the  
15 previous years, and I could very well, I think, understand why  
16 the funding levels were all of such a small nature when it is  
17 obvious that one can see perhaps a change in direction with  
18 obvious involvement of the community resources and the progress  
19 is to be made.

20 I wonder perhaps if we would not want to consider  
21 not to put a program in jeopardy because of insufficient  
22 funding to give them a little bit more. Because I think it  
23 looks like that they just had \$431,000 and to give them  
24 \$70,000 more with such a tremendous change in direction, I  
25 wonder would we not stymie their efforts and probably break

1 their spirit.

2 DR. SCHMIDT: They were at \$323,401.

3 MISS KERR: For 16 months.

4 DR. SCHMIDT: The 431 was 16 months. So the  
5 annualized level was \$323. So this would be \$200,000  
6 addition in essence.

7 DR. JAMES: I would like to recommend around \$600,000.

8 DR. SCHMIDT: Well, that is out of order. There is  
9 a motion on the floor. I will ask for a second. And then  
10 if the motion dies, we will have to --

11 DR. LUGINBUHL: Second.

12 DR. SCHMIDT: All right, there is then a seconded  
13 motion on the floor at \$525,000.

14 Mr. Toomey.

15 MR. TOOMEY: No, that answered my question when you  
16 annualize those dollars for salary.

17 DR. SCHMIDT: It is \$323,401 annualized.

18 Dr. Hess.

19 DR. HESS: I notice that substantial part of their  
20 increase is for core staff. And I didn't hear too much about  
21 what that was going to do.

22 We do have a letter here which says all their  
23 currently budgeted staff positions are now filled. And do  
24 you have a good feel for what the additional core staff money  
25 will do for that program?

1 MR. POSTA: Excuse me, if you take a look at page 6  
2 on the yellow sheet, there is last year's request and also  
3 an attempt to break down to the annualized level for the  
4 last year. So that that would give you some basis for  
5 comparison all the way down the line.

6 MR. FLANERTY: In a nutshell, to compromise the two  
7 positions that existed at the time of their RAG meeting  
8 approving this application, one was to come in for the full-  
9 blown package with no feasibility studies. The other was to  
10 come in with core staff and feasibility studies only. So what  
11 they did was to come in with a full-blown operation one-year  
12 package with feasibility studies. So there is \$120,000 of the  
13 program staff request that is for feasibility studies as was  
14 recommended by their planning and evaluation committee to further  
15 design and assess their needs that exist in North Dakota.

16 MISS KERR: The orientation of these three new  
17 people who are in key positions will take a spot of time, too,  
18 as we talked about it.

19 DR. SCHMIDT: Leonard, comments on the \$525,000 level?

20 DR. SCHERLIS: I think that is realistic. It is a  
21 very significant increase over what they have now. And it is  
22 compared to what. As compared to \$323,000 that we are talking  
23 about \$525,000.

24 I don't know if they could spend as much as they are  
25 asking for with new leadership. I am sure they will spend

1 the \$525,000 very well. They would probably spend \$550,000  
2 or \$575,000, too, but I think \$700,000 is high. Where you  
3 place it in between, I think is a matter of judgment.

4 MISS KERR: If there is a strong enough feeling  
5 among the group, I will rescind the motion for a compromise.

6 DR. JAMES: Let me say that now that I have had a  
7 clearer understanding of what the annualized funding was, I  
8 can more readily accept the figure.

9 DR. SCHMIDT: John.

10 DR. KRALEWSKI: This committee is getting too  
11 friendly.

12 I like the --

13 DR. SCHMIDT: I am interested in what is coming now.

14 DR. KRALEWSKI: I like your suggested amount, but I  
15 wonder if you would have some advice to them as to how much  
16 of that should be spent for core staff and how much should be  
17 spent on projects or can we do that? Maybe we can't. I think  
18 their core staff is getting pretty large for that small area.

19 DR. SCHMIDT: We can give them advice. Generally,  
20 our funding level we arrive at by saying so much for core,  
21 so much for projects, but then the money is theirs.

22 DR. KRALEWSKI: If they keep using it up with core,  
23 they are going to do some really fantastic studies that really  
24 look great, but --

1 total amount budgeted for core.

2 DR. SCHMIDT: Again, it is 70 percent of what?

3 MISS KERR: Well, their total.

4 DR. SCHMIDT: All righty. Going once, going twice.

5 All right, I will put the question then. And the

6 motion is one year at \$525,000.

7 All in favor please say, "Aye."

8 (Chorus of ayes.)

9 Opposed, "No."

10 (No response.)

11 And that motion carries.

12 All right, the group has done well. We have five

13 major reviews out of the way. Tomorrow we have five more

14 and then a number of anniversaries within the triennium of

15 another 9 regions.

16 So that in answer to some questions about how long

17 we would go, I would wish that people not change their planes

18 to too early in the day. I would think we would probably go

19 until after lunch unless we don't discuss regions an hour at

20 a crack which is kind of what we have been doing.

21 So I will predict we will finish at 2, 2:30 type of

22 thing tomorrow.

23 DR. THURMAN: Metro New York will carry us to there,

24 Mr. Chairman.

25 DR. SCHMIDT: All right, let's make it 3:30. In

1 other words, I don't think we are going to finish at noon.

2 Your rating sheets, you can leave right here with the  
3 material, and we will reconvene at 8:30 and begin sharply  
4 then.

5 Thank you.

6 (Whereupon, at 5:30 o'clock p.m., the meeting  
7 recessed, to reconvene at 8:30 a.m. on Thursday, January 18,  
8 1973.)  
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